



2026

Retiree Benefits Overview

Making Benefits Work For You

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What's New or Changing?

Introducing Navitus Pharmacy Benefits–

Navitus is replacing Express Scripts (ESI) for prescription drugs benefits beginning 01/01/2026. See page 11 for more information.

Introducing Digbi Health–

Eligible Anthem members can enroll in Digbi Health, a highly personalized program that helps manage obesity, diabetes, cardiometabolic conditions, and digestive health beginning 01/01/2026. See page 10 for more information.



MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

Getting Started

The benefits in this summary are effective **January 1, 2026** through **December 31, 2026**

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, San Bernadino Municipal Water Department supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

A pre-recorded presentation providing a broad explanation of 2026 benefits is available by clicking the link below: <https://www.brainshark.com/1/player/alliant?custom=sbmwdoe2026>



IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.



Open Enrollment

OPEN ENROLLMENT

October 6 – October 17, 2025

Open Enrollment is your once-a-year opportunity to elect, change, cancel your benefits coverage, or add/drop dependent coverage. Here is some important information regarding this year's Open Enrollment. Please consider your options carefully because you may only make changes to your benefit elections during Open Enrollment or if you experience a mid-year "qualified status change". All Open Enrollment benefit changes will be effective **January 1, 2026**.

2026 Offerings:

- Kaiser Senior Advantage HMO (PRISM)
- Anthem Medicare Supplement Plan (PRISM)

Retiree Billing

Benefit Coordinators Corporation (BCC) will continue as the administrator who will be managing the retiree billing and eligibility. If you have questions, please call (855) 230-0745 Ext. 6414.

All enrollment and/or changes must be completed by contacting BCC Customer Service at (855) 230-0745 Ext. 6414 prior to October 17th at 3:00pm (PST). No action is required if you are not making any changes to your current medical plan.

If you have any questions regarding enrollment or plan changes, please contact BCC Customer Service at the number above.

Who is Eligible?

Retiree Eligibility

After your initial enrollment, unless you qualify for a “special enrollment”, you cannot make changes in your election until the next “open enrollment”. Please see Page 6 for “special enrollment” qualifications. You are allowed to terminate your coverage at any time during the year by submitting a written request to SBMWD; however, once you have submitted this request, there will be no reinstatement.

The following dependents are eligible for benefits:

- Your legal spouse. Proof of marriage certificate and Social Security Number are required.
- Your domestic partner. Must be registered with the California State Registry and at least 18 years of age. Proof of domestic partnership and Social Security Number are required.
- Your or your domestic partner’s natural children, stepchildren, adopted children and/or children of which the employee or domestic partner is the legal guardian. Proof of birth certificate and Social Security Number are required. In addition, dependent children must meet the following age requirements:
 - Dependents are eligible up to age 26 for Medical.
 - Your physically or mentally handicapped children who meet the plan eligibility guidelines and depend on you for support, regardless of age

Members who are NOT eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.

Documentation

Birth and marriage documents are required when enrolling.

Changing Your Benefits

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualifying status change or qualify for a “special enrollment”. If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by your spouse, or your dependent child
- **Change in work schedule**, including an increase or decrease in hours of employment by your spouse, or your dependent child; or a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child’s dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite**, including a change that affects the accessibility of network providers
- **Change in your health coverage or your spouse’s coverage**, attributable to your spouse’s employment
- **Change in an individual’s eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a “special enrollment” under the Health Insurance Portability and Accountability Act (HIPAA)**, including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **You will not be able to re-enroll in a retirement plan if your coverage is canceled.**

Two rules apply to making changes to your benefits during the year:

- **Any changes you make must be consistent with the change in status, AND**
- **You must make the changes within 30 days of the date the event (marriage, birth, etc.) occurs (unless otherwise noted above).**

Please note the following effective dates in regard to Qualifying Events:

- **Adds, terms and changes are effective First of the Following Month of the event.**
- **There are two exceptions**
 - **Birth of a child – added on date of birth**
 - **Death of a Member – term the day after death**



Medical

Our medical plans offer comprehensive coverage. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose.

Medical Plan Overview

This guide serves as a summary of the medical plans. Please review the plan documents before selecting a plan.

	What you need to know
Kaiser Senior Advantage Plan(Retirees with Medicare Parts A&B)	• Access to Kaiser providers/facilities exclusively • Requires PCP to see specialist • No deductible • Predictable costs
Anthem Medicare Supplement Plan (Retirees with Medicare Parts A&B)	• National provider access • No deductible • Preventive care; no charge

Kaiser HMO (PRISM) Senior Advantage HMO with Part D (Retirees with Medicare Parts A&B)

This table shows member cost share.

	Kaiser HMO (PRISM) Senior Advantage HMO with Part D (Retirees with Medicare Parts A&B)
	In-Network Only
Annual Deductible Individual Coverage/ Family Coverage	None
Annual Out-of-Pocket Maximum^{2,3}	\$1,000 per member
Lifetime Max	Unlimited
Office Visit Primary Care Specialist	\$20 copay \$20 copay
Preventive Services	Plan pays 100%
Chiropractic Care	\$15 copay (up to 20 visits per year)
Lab and Imaging	No copay
Inpatient Hospitalization	\$500 per admit
Outpatient Surgery	\$50 per procedure
Urgent Care	\$20 copay
Emergency Room	\$50 copay (copay waived if admitted)
PRESCRIPTION DRUGS- Senior Advantage HMO	
Prescription Drugs Deductible	None
Annual Out-of-Pocket Maximum	Combined with medical
Pharmacy- 30 Day Supply Generic Preferred Brand Non-preferred Brand	\$10 copay \$25 copay \$25 copay
Mail Order- 100 Day Supply Generic Preferred Brand Non-preferred Brand	\$20 copay \$50 copay \$50 copay

²This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.

³All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

Medicare Supplement Plan

This table shows member cost share.

	Anthem (PRISM) Medicare Supplement Plan (Retirees with Medicare Parts A&B)	
	In-Network	Out-of-Network
Lifetime Max	\$1,000,000	
Deductible Part A	None, Plan Pays Part A Deductible	
Annual Out-of-Pocket Maximum ³ Individual Coverage	N/A	
Part A		
Hospitalization	No Charge	
Inpatient		
Lab and Imaging CT, MRI, PET scans Other lab and x-ray	No Charge No Charge (amounts in excess of reasonable through the 515 th day) No Charge (amounts in excess of reasonable through the 515 th day)	
Part B		
Physician Office Visit	Medicare Part B Deductible + amount over allowable charge	
Specialist Copay	Medicare Part B Deductible + amount over allowable charge	
Preventive Care	No Charge	
Outpatient	Medicare Part B Deductible + amount over allowable charge	
Other Services		
Emergency Room	No Charge	
PRESCRIPTION DRUGS -Medicare Supplement Plan		
	In-Network	Out-of-Network
Prescription Drugs Deductible	None	None
Annual Out-of-Pocket Maximum	None	None
Pharmacy Tier Name 1 Tier Name 2 Tier Name 3 Specialty Supply Limit	\$10 copay \$20 copay \$35 copay 25% maximum of \$150 per fill 30 days	
Mail Order Tier Name 1 Tier Name 2 Tier Name 3 Specialty Supply Limit	\$15 copay \$30 copay \$50 copay 25% maximum of \$300 per fill 90 days	Not covered Not covered Not covered Not applicable

³All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

NEW! Digbi Health - Diabetes, Obesity & GI Care



Your Digbi Health Journey

The Digbi Health program is a personalized 52-week journey designed to transform your health and wellness. Whether you're managing your weight, Type 2 Diabetes, digestive health, or taking GLP-1s for weight management, Digbi is here to support you with care tailored to your biology. Digbi Health is available at no cost for eligible members covered by Anthem through your employer.

This program includes:

- Gut & Gene Testing Kits
- Glucose Monitoring Device
- Tailored Meals
- Health Coach
- GLP-1s for weight management

Contact Digbi at prism@digbihealth.com or at (866) 344-2189 if you have any questions.

GLP-1 Eligibility

Eligibility requirements for accessing GLP-1s for weight management:

- 18 years or older and enrolled in Anthem (Mandatory).
- BMI 40 or higher without any comorbidity (OR)
- BMI 35 - 39 with at least one related comorbidity (OR)
- Mandatory: If you're on a GLP-1 for weight management, you should have lost 5% weight within 90 days of starting them.
- Digbi to be the sole prescriber for all weight loss medications.

Get Started

1. Check your eligibility and sign up for the program at digbihealth.com/prism.
2. If you are eligible, download mobile app - onelink.to/digbi.
3. On the app, please confirm shipping address and answer onboarding questions - your kits will be ordered to your address, automatically.
4. Starting January 1, 2026, you will have 90 days to go through Digbi Health's Reauthorization for weight management GLP-1 medication based on the new eligibility criteria.

Digbi Health App

- **Get at-home Test Kits** - Within a week, you'll receive a comprehensive testing kit including a Genetic Test, a Gut Microbiome Test, and an Abbott Libre Continuous Glucose Monitor. Please follow instructions to collect samples and return kits using pre-labeled shipping.
- **Sync your Health Apps** - Connect Apple or Google Health Apps with the Digbi App. Navigate to settings, choose "Health", then connect by tapping "Refresh" under "Apple Health".
- **Say hi to your Coach!** - Tap the 'Coach' button at the bottom to start engaging with your health coach on the app and upload meal pictures for scoring while you await test results.

NEW! Prescription Drugs – Navitus

Filling Your Prescriptions

Anthem members have access to prescription drug coverage through Navitus.

- **Network Pharmacy** – Most independent and all major chain pharmacies, are part of your benefit network.
- **Costco Mail Order** – A 90-day supply of maintenance medications can be mailed right to your door. You don't need to be a Costco member to use their pharmacies. Just register online at pharmacy.costco.com or call (800) 607-6861 to get started.
- **Specialty Pharmacy** - Lumicera Health Services, our specialty pharmacy partner, provides a high level of personalized care for members with complex conditions. Their clinical team will help you manage side effects and reduce complications, so you can focus on the things that matter most. Visit lumicera.com/patients/ or call (855) 847-3553 for more information.

Member Portal & App

Go to navitus.com/members to access the member portal or download the Navitus mobile app. Register for your account, if you haven't already done so. Log into the Navitus member portal and app with the same username and password. Once registered, click Sign In, then enter your login details and password. From here you can:

- View or print your member ID card
- Perform a Drug Search for coverage details
- Find drug prices and pharmacy locations
- Easily track your medication history

***Please note that all members will be getting a replacement Pharmacy Card!**

Simplifying Prior Authorization, Step Therapy & Exception to Coverage

There are certain conditions and medications which require extra steps to gain approval to fill the prescription, but Navitus tries to make it as easy as possible.

- **Prior Authorization (PA)** – Some prescriptions require prior authorization to be filled, which your health care provider will need to help facilitate. Drugs that need prior authorization are listed on your formulary with a PA. Most prior authorization requests are reviewed within two business days and urgent requests within one business day.
- **Step Therapy** – When there's an effective alternative available that's less expensive for you, you may be asked to try that before a more expensive prescription is authorized.
- **Exception to Coverage (ETC)** – If a drug isn't approved, you and your doctor can submit an ETC request showing alternative medications aren't effective or suitable for your personal situation.
- **Coverage Details** - If there are any limits or requirements on your medications like the ones listed above, a Coverage Details button will appear on the medicine's description page in the portal. Clicking on that button will outline what's needed to get the prescription filled.

Navitus Customer Care

Carrier ID: NVPSM

Phone: [855-847-1035](tel:855-847-1035)

Website: <https://benefitplans.navitus.com/NVPSM>

Available 24 hours a day, 7 days a week; Closed Thanksgiving & Christmas



Important Plan Information

In this section, you'll find important plan information, including:

	What you need to know
Your Benefit Costs	An overview of your healthcare costs.
Important Contacts	Contact information for our benefit carriers and vendors.
Important Notices	A summary of the health plan notices you are entitled to receive annually, and where to find them.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify San Bernadino Municipal Water Department if your domestic partner is your tax dependent.

Monthly Medical Premiums

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage.

Rates do not include contribution amounts. Please refer to your Open Enrollment memo or contact Human Resources at (909) 453-6091 for 2026 contribution amounts and questions.

Medical	Anthem Medicare Supplement Plan	Kaiser Senior Advantage Plan
Single	\$952.50	\$223.50
2 Party		
• Both Medicare	\$1,888.50	\$429.50
• 1 Medicare, 1 Without	\$2,203.50	\$1,021.50
Family		
• All Medicare	\$2,537.50	N/A
• 1 Medicare, 2 Without	\$3,067.50	\$1,570.50
• 2 Medicare, 1 Without	\$2,752.50	\$978.50

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website/Email	Policy No.
Medical	Kaiser Senior Advantage	800-464-4000	www.kp.org	232111
Medical	Anthem Blue Cross Medicare Supplement Plan	800-759-3030	www.anthem.com/ca/prism	175075
Medical	Navitus	855-847-1035	https://benefitplans.Navitus.com/NVPSM	N/A
Billing & Eligibility	Benefit Coordinators Corporation (BCC)	855-230-0745 Ext. 6414	N/A	N/A
457 Deferred Compensation	Empower	800-743-5274	www.retiresmart.com	63122
San Bernardino Municipal Water Department	Human Resources	909-453-6091	www.sbmwd.org hr@sbmwd.org	N/A

Important Plan Information

Health Plan Notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **ACA Disclaimer** This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee inly coverage under our base plan exceeds 9.12% in 2026 of your modified adjusted household income.
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

Medicare Part D Notice

Important Notice from The San Bernardino Municipal Water Department About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the San Bernardino Municipal Water Department and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The San Bernardino Municipal Water Department has determined that the prescription drug coverage offered by the Anthem and Kaiser plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your San Bernardino Municipal Water Department coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the San Bernardino Municipal Water Department's creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your San Bernardino Municipal Water Department prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the San Bernardino Municipal Water Department and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the San Bernardino Municipal Water Department changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2026
Name of Entity/Sender:	San Bernardino Municipal Water Department
Contact-Position/Office:	Human Resources
Address:	1350 S. E Street, Building B, San Bernardino, CA 92408
Phone Number:	(909) 453-6091

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the San Bernardino Municipal Water Department' health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the San Bernardino Municipal Water Department' health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the San Bernardino Municipal Water Department' health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Notice of Choice of Providers

The Anthem and Kaiser HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Anthem and Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Anthem or Kaiser customer service.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Anthem or Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Anthem or Kaiser customer service.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 (9.02% in 2025) of your modified adjusted household income.

