

Medicare Advantage Group Plan Enrollment Guide

Santa Clara Valley Water District

Anthem Medicare Preferred (PPO) with Senior Rx Plus

1/1/2027 – 12/31/2027

Anthem

Valley Water

Get to know the plan

We're here to help

There can be a lot to sort through when it comes to selecting a health and prescription drug plan and managing your health. We created this guide to help you understand the basics of our Anthem BC Health Insurance Company group Medicare plan. From choosing a doctor to learning about our convenient online tools and health programs, the important information is all right here at your fingertips. As you read, you will learn that Original Medicare doesn't cover everything. Group-sponsored coverage from your employer, like Medicare Advantage from Anthem, usually offers more.

If you have questions or need help, call our RetireeFirst Member Advocate Line, **1-855-301-8203** (TTY: **711**) Monday through Friday, 8 a.m. to 5 p.m. PT.

The plan at a glance



Santa Clara Valley Water District offers you the Anthem Medicare Preferred (PPO) with Senior Rx Plus plan. This plan includes medical and prescription drug coverage, along with additional benefits and programs. CarelonRx is the pharmacy benefit manager for your plan. Preferred Provider Organizations (PPOs) use a network of doctors, hospitals, and other care providers. You can see any doctor and visit any hospital you'd like as long as they accept Medicare and the plan.

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Medical benefit highlights

This plan covers many medical services, treatments, and tests. Plus, you can protect your health by getting your recommended checkups, shots, and screenings with preventive care services at no cost[1] Here are some of the benefits that may be included:

Health and wellness

- Inpatient hospital care and ambulance services
- Emergency and urgent care, including access to emergency care across the U.S. and outside of the country[2]
- Skilled nursing facility benefits
- Complex radiology services and radiation therapy
- Diagnostic procedures and testing services received in a doctor's office
- Lab services and outpatient X-rays
- Tobacco cessation counseling
- Hearing care
- Vision care

Nutrition

- Diabetes services and supplies
- Medical nutrition therapy[3]
- Obesity screening and therapy[3]

Preventive care services

- Annual wellness visit and routine physical exam[4]
- Blood pressure and cholesterol tests
- Breast cancer (mammogram) screening
- Colorectal cancer (colonoscopy) screening
- Diabetes (blood sugar, kidney, retinopathy) screening
- Osteoporosis (bone density) screening
- Immunizations like flu and pneumococcal shots

Devices

- Durable medical equipment and related supplies
- Prosthetic devices



See your Summary of Benefits located in the appendix for more details.

1 Provider must be in your plan's network. For some PPO plans, copays or coinsurance may apply if you use an out-of-network provider. Out-of-network providers must accept both Medicare and our plan. Refer to the Summary of Benefits or Benefit Chart in your Evidence of Coverage for details about your coverage and costs.

2 Some plans may not include emergency coverage outside of the country, check your benefit chart in your Evidence of Coverage.

3 Benefit available if qualifying conditions are met.

4 Some plans may not include coverage for an annual routine physical exam; check your benefit chart in your Evidence of Coverage.

Prescription drug benefit highlights

Covered medications

- Find commonly prescribed brand-name and specialty drugs that Medicare Part D allows us to cover, plus more drugs beyond what Original Medicare covers called Extra Covered Drugs.
- Choose from a wide range of generic drugs to save even more money — and without sacrificing effectiveness.

Network pharmacies

- Access to a vast network of pharmacies to save money on your prescriptions.
- Most national chains and many local pharmacies are in our network.

Get your medications through mail

Save time by not waiting in line at the pharmacy and enjoy the convenience of having your maintenance medications delivered straight to you. With mail order pharmacies in your network, such as CarelonRx Pharmacy[1], you can receive up to 90 days of supplies and maybe even save money than filling your prescription at a regular pharmacy. You can explore home delivery for your prescriptions and set it up anytime through your online account or on the **Sydney® Health** app. [2, 3]

Generics have the same active ingredients and effects as brand-name drugs, generally without the higher cost share.



1 CarelonRx Pharmacy is a separate company that provides mail order pharmacy services in your health plan's pharmacy network. You can choose any pharmacy in our network.

2 Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.

3 Online tools are offered to Anthem plan members as extra services. They are not part of the contract and can change or stop.

Access to care

Discover a wide network of Medicare providers who deliver high-quality care.

Choose the doctors you want

You can see any doctor, specialist, or other care provider in or out of your plan's network who accepts both Medicare and the plan.

You will also benefit from:

- Paying the same copay or coinsurance amount, whether or not you see a care provider in or out of your plan's network.*
- Your benefits and coverage stay the same, no matter where you travel in the country. The Blue Cross and Blue Shield Association connect local BCBS networks, providing you access to a broad nationwide provider network. If you live in a state where you don't recognize the Anthem name and would like someone to confirm the plan is effective in your area, please call our RetireeFirst Member Advocate Line.

What if a doctor says they don't accept this plan?

Ask the doctor or care provider to call the phone number on the back of your medical and pharmacy ID card. We'll explain to them how they can submit a claim for your visit.

How to find care

Once you enroll, you'll be able to use our helpful Find Care tool to search for doctors and other care providers in your area.

Are you ready to enroll?

Visit page 13 to get started.



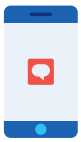
Questions?

Call our RetireeFirst Member Advocate Line for answers or plan details at **1-855-301-8203** (TTY: **711**), Monday through Friday, 8 a.m. to 5 p.m. PT.

* Out-of-network or noncontracted care providers are not obligated to treat plan members except in emergency situations. Contact the RetireeFirst Member Advocate Line for more information.

Perks and programs

This plan includes useful tools and programs to support your health and well-being — at no additional cost. Once you enroll, you'll have access and can begin using these valuable benefits.



Manage your health with our online tools and programs

Sydney Health app[1]

The Sydney® Health app offers you ways to stay healthy and manage your health plan, all from the palm of your hand.[2]

After you receive your ID card, you can download the app from the App Store® or Google Play™. Then use the information on the card to set up your account. It only takes a few minutes to register.

Use the app to:

- See a live doctor via a virtual visit.
- Access plan and health resources.
- Check the status of claims.
- Use home delivery for prescription drugs.

MyHealth Advantage[6]

MyHealth Advantage sends you mailed reminders about ways to protect your health. You'll also have access to health specialists who can answer your questions.

LiveHealth Online[3]

Visit with a doctor, therapist, or psychiatrist through live video on your phone, tablet, or computer with a camera. It's a great way to:

- Access a healthcare professional in the comfort of your home, 24/7.
- Find help with common conditions like the flu, colds, sinus infections, pink eye, and skin rashes — and even have prescriptions sent to the pharmacy if needed.[4]
- Set up a 45-minute counseling session with a licensed therapist to find help when you feel depressed, anxious, or stressed. You can also meet with a board-certified psychiatrist to get medication management support if talk therapy alone isn't enough.[5]
- With the Anthem plan, video visits using LiveHealth Online are $0.

1 Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.

2 Online tools are offered to Anthem plan members as extra services. They are not part of the contract and can change or stop.

3 LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

4 Prescription availability is defined by physician judgment.

5 Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LiveHealth Online will not offer counseling or talk therapy. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Call 911 or call or text the 988 Suicide & Crisis Lifeline at 988 and ask for help.

6 Carelon Health, Inc. is a separate company providing care management services on behalf of your health plan. In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Perks and programs



Convenient care services

The House Call program

Receive an annual in-home or virtual health evaluation from a licensed clinician in the comfort of your own home to support the ongoing care you receive from your doctors.

24/7 NurseLine[7]

24/7 NurseLine puts you in touch with a registered nurse anytime of the day or night.

Carelon Health Palliative Care[8]

In the event of a serious illness, Carelon Health Palliative Care is a non-hospice, community-based program that can provide an extra layer of support. A physician-led team of advanced practice providers, nurse practitioners, nurses, and social workers would work with your primary care provider to coordinate care. The Carelon Palliative Care clinical team is available 24/7 through a help line. They provide extra care and attention, as well as education about illness, your plan of care, and medications. These services are provided through a combination of either home-based visits and telehealth support or virtual care and support for you and your caregivers.



Questions?

Call our RetireeFirst Member Advocate Line for answers or plan details at **1-855-301-8203** (TTY: **711**), Monday through Friday, 8 a.m. to 5 p.m. PT.

7 The information contained in this program is for general guidance only. Your doctor will be specific regarding recommendations for your individual circumstances. Recommended treatments may not be covered under your health plan.

8 The Carelon companies are separate companies providing behavioral health, care pathways, pharmacy, and value-based care delivery solutions through our digital platforms and technology services and research on behalf of your health plan.

Perks and programs

Supporting your whole health

SilverSneakers®

SilverSneakers is a fitness and lifestyle benefit that offers the opportunity to connect with your community, make friends, and stay active. Your membership gives you:[9]

- Access to thousands of participating locations with use of basic amenities, plus group exercise classes for all levels at select locations.[10, 11]
- The SilverSneakers GO app so you can find locations near you, participate in live classes from your phone, and tailor workouts to your fitness level.
- Access to SilverSneakers LIVE virtual classes and the On-Demand library with hundreds of online videos so you can work out at home.

To find a location near you or join virtual classes, visit **www.SilverSneakers.com/StartHere** or call **1-855-741-4985**, TTY: **711**, Monday to Friday, 8 a.m. to 8 p.m. ET.

Please review your Summary of Benefits for more perks and programs available to you!

9 Always talk with your doctor before starting an exercise program.

10 Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

11 Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved.

What is Medicare?

Medicare is a federal government health insurance program for people 65 or older. You may also be eligible if you:

- Are under age 65 with certain disabilities
- Have end-stage renal disease (ESRD)
- Have amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease

More information is available at **www.medicare.gov**, or you can call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Medicare is available as follows:



Original Medicare

- Part A provides coverage for hospital benefits.
- Part B provides medical benefits.



Medicare Advantage

- Also called Part C.
- Bundles Parts A and B.
- Offers supplemental benefits and a first-class member service experience.
- Can include Part D, the prescription drug plan.

Medicare Advantage is a Medicare-approved plan available only through private insurance companies. The added benefits it offers are listed throughout this guide.

Original Medicare = government program		**Offered by private insurance companies**	
Medicare Part A	**Medicare Part B**	**Medicare Part C**	**Medicare Part D**
Original Medicare + Part C = Medicare Advantage			
Medicare Advantage + Part D = MAPD plan			

Medicare Advantage vs. Original Medicare



Compare coverage

The good thing about Medicare Advantage is that it limits how much you'll spend each year on treatment. Plus, the prices are often fixed, so you'll have a better idea of any costs beforehand.

Medicare Advantage can include prescription drug coverage (Part D) — something Original Medicare doesn't offer.

Medicare Advantage	Original Medicare
Plan pays 100% of covered medical costs for rest of plan year after annual out-of-pocket maximum is met*	No limit to medical costs you will pay annually — no annual out-of-pocket maximum
You will often pay copays (fixed dollar amounts)	You will pay a percentage of cost (20% of the cost for common services like outpatient surgery and doctor visits)
Can include Part D prescription drug coverage	No Part D prescription drug coverage
Emergency and urgent care, including access to emergency care across the U.S. and outside of the country[2]	No emergency care coverage outside of U.S.

1 Not all medical costs are included in or are subject to the annual out-of-pocket maximum. Call our RetireeFirst Member Advocate Line if you have questions about plan benefits. 1-855-301-8203 (TTY: 711) Monday through Friday, 8 a.m. to 5 p.m. PT.

2 Some plans may not include emergency coverage outside of the country, check your benefit chart in your Evidence of Coverage.

Medicare Part D

The prescription drug plan described in this guide is also known as a Medicare Part D plan. All of our covered drugs appear on a drug list called the Part D formulary. This plan also covers drugs beyond those that Medicare Part D covers, which appear on a separate list called Extra Covered Drugs.



If you take a drug that is not covered, you have three options:

- Ask your doctor to switch you to a covered drug
- Request an exception
- Request a temporary supply while discussing other drug options

Covered drugs are divided into levels or tiers. Drugs on the lowest-numbered tier generally cost less, while drugs on the highest-numbered tier generally cost the most. Each tier contains drugs that we cover based on their safety and effectiveness. This chart provides an overview of how the tiers and pricing generally work.

Drug type	Description	Possible tier coverage	Cost
Generic[1, 2]	Same active ingredients and effects as the brand-name drug, but usually costs less	Tier 1	$
Preferred drug	Safe and effective lower cost drug	Tier 2	$$
Non-preferred drug	Generally have more cost-effective alternatives on lower tiers	Tier 3	$$$
Specialty	Cost $1,080 or more for a 30-day supply. May require special handling.	Highest tier	$$$$

The tier level for each drug type may vary depending on the number of tiers on your formulary.

1 High-cost generic medications may also appear on the same tiers as brand-name medications. Please consult the formulary for specific tier details.

2 Some drug lists divide generic drugs into two tiers. Please consult the formulary for specific tier details.

How to qualify and enroll

If you would like to participate in the Anthem Medicare Preferred (PPO) with Senior Rx Plus plan, please call a Dedicated RetireeFirst Advocate at 855-301-8203 (TTY 711), 8:00 a.m. to 5:00 p.m. Pacific Time.

Qualifications for enrolling in Anthem Medicare Preferred (PPO) with Senior Rx Plus:

- You are a United States citizen or national, or an eligible noncitizen.
- You live in the plan's geographic service area. People who are incarcerated aren't considered to be in the geographic service area even if they're physically located in it.
- You are now entitled to Medicare Part A and enrolled in Part B.
- You keep paying your Medicare Part B premiums, unless they are paid by Medicaid or through another third party.
- You qualify for coverage under your or your spouse's group-sponsored health plan.

Generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a retroactive or future date is requested and is allowed.

Understanding the Medicare Prescription Payment Plan:

This is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for Part D covered drugs by spreading them across the calendar year (January - December). It does not apply to Part B drugs. It also does not apply to Extra Covered Drugs if your plan includes this benefit. Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.

"Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option. To learn more about this option, call us at 1-833-246-7717 (TTY users call 711) or visit **www.medicare.gov**.

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What to expect after you enroll



How to give others access to your health records

Fill out your Member Authorization Form at **www.anthem.com/ca/forms** to give people that you choose access to your health records.



Keep an eye on your mailbox

After you enroll, you can sit back and relax. Once your enrollment is processed, you will receive:

- Proof of your enrollment request with your membership start date listed.
- Your ID card. You can begin using this card on your membership start date.
- A health survey to help us understand and address your needs. Within your first 90 days, we will call you to answer a simple health survey to help keep your care and services up to date.



Look out for your plan Welcome Guide

This guide can help you:

- Learn how to contact us.
- Access plan documents online.
- Find the right resources for more information.

Summary of Benefits

We've provided a Summary of Benefits so you can have a better understanding of what's covered and what's not, including*:

- Costs you are responsible for
- What we cover under the plan
- Any copays or percentage of the cost
- Any out-of-pocket costs



Questions?
Call our RetireeFirst Member Advocate Line for answers or plan details at **1-855-301-8203** (TTY: **711**), Monday through Friday, 8 a.m. to 5 p.m. PT.

* For a full list of benefits and cost share, see the benefit chart in the Evidence of Coverage.

Santa Clara Valley Water District

2027 Summary of Benefits

PPO Plan 10PH

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com/CA**, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Anthem Medicare Preferred (PPO) Benefits Effective: 01/01/2027 – 12/31/2027

Plan Features	In-network:	Out-of-network:
Annual medical deductible:	$0 combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$1,000 combined in-network and out-of-network	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care*	$0 copay per admission No limit to the number of days covered by the plan.	$0 copay per admission No limit to the number of days covered by the plan.
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$0 copay per visit	$0 copay per visit
Outpatient hospital services observation room	$0 copay per visit	$0 copay per visit
Doctor visits - Primary care provider	$10 copay per visit	$10 copay per visit
Doctor visits - Specialist	$30 copay per visit	$30 copay per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$100 copay per visit $100 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Urgently needed services	$10 copay per visit $10 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Diagnostic services, labs and imaging - X-ray visit and/or simple diagnostic test*	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Diagnostic services, labs and imaging - Complex diagnostic test and/or radiology visit*	$0 copay per visit	$0 copay per visit
Diagnostic services, labs and imaging - Radiation therapy treatment*	$0 copay per visit	$0 copay per visit
Diagnostic services, labs and imaging - Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$30 copay per visit	$30 copay per visit
Routine hearing services‡† We have partnered with TruHearing to bring you these discounts and services.	Must use a TruHearing participating provider. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids $2,000 maximum benefit every two calendar years	**Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids supplied by TruHearing $2,000 maximum benefit every two calendar years 80% coinsurance for hearing aids not supplied by TruHearing

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Medicare-covered dental is non-routine care performed by your specialist*	$30 copay per visit	$30 copay per visit
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$10 copay per visit	$10 copay per visit
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	$0 copay per surgery	$0 copay per surgery
Routine vision services†	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** $0 copay for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network	Member must submit a claim form for reimbursement **Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network **Non-elective contact lenses** 100% reimbursement for non-elective contact lenses 1 pair every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital*	$0 copay per admission No limit to the number of days covered by the plan.	$0 copay per admission No limit to the number of days covered by the plan.
Mental health professional individual therapy visit	$10 copay per visit	$10 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Substance use disorder professional individual therapy visit	$10 copay per visit	$10 copay per visit
Skilled nursing facility (SNF) care*	$0 copay for days 1-100 per benefit period 100-day limit per benefit period	$0 copay for days 1-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$10 copay per visit	$10 copay per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $100 copay per one-way trip for ambulance services	
Medicare Part B drugs*	$0 copay for Part B drugs	$0 copay for Part B drugs
Chiropractic services Medicare-covered	$10 copay per visit	$10 copay per visit
Additional chiropractic services	$10 copay per visit 30 visits per year combined in-network and out-of-network, for both additional chiropractic services and additional acupuncture services combined	$10 copay per visit 30 visits per year combined in-network and out-of-network, for both additional chiropractic services and additional acupuncture services combined
Acupuncture for chronic low back pain Medicare-covered	$10 copay per visit	$10 copay per visit
Additional acupuncture services	$10 copay per visit 30 visits per year combined in-network and out-of-network, for both additional acupuncture services and additional chiropractic services combined	$10 copay per visit 30 visits per year combined in-network and out-of-network, for both additional acupuncture services and additional chiropractic services combined
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase for FreeStyle® (made by Abbott) and ACCU-CHEK® (made by Roche Diagnostics) $10 copay per purchase for all other brands when purchased through the pharmacy
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom	$0 copay per purchase for FreeStyle Libre® (made by Abbott) and Dexcom
Durable medical equipment (DME) and related supplies*	20% coinsurance per purchase	20% coinsurance per purchase
Opioid treatment program services*	$0 copay per visit	$0 copay per visit
Podiatry services*	$10 copay per visit	$10 copay per visit
Routine foot care Includes the cutting or removal of corns and calluses, the trimming, cutting, clipping, or debriding of nails, and other hygienic and preventive maintenance care.	$10 copay per visit 12 visits per year combined in-network and out-of-network	$10 copay per visit 12 visits per year combined in-network and out-of-network

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Home health agency care*	$0 copay per visit	$0 copay per visit
Hospice care	$0 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$0 copay for the one time only consultation 1 visit per lifetime When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.

Additional covered benefits and services	In-network, Member pays unless specified:	Out-of-network, Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online	
Health and wellness education programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit	Reimbursed up to $10 per month for visits to a qualified fitness facility
24/7 NurseLine†	$0 copay for 24/7 NurseLine	
Foreign travel (outside U.S. and its territories) Emergency care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Emergency care** $100 copay for emergency care $100 copay is waived if the member is admitted to the hospital within 72 hours for the same condition. **Maximum Benefit** $10,000 maximum benefit per lifetime for all foreign travel emergency care, urgently needed care services, or inpatient care	

Additional covered benefits and services	In-network, Member pays unless specified:	Out-of-network, Member pays unless specified:
Foreign travel (outside U.S. and its territories) Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $10 copay for urgently needed services $10 copay is waived if the member is admitted to the hospital within 72 hours for the same condition. **Maximum Benefit** $10,000 maximum benefit per lifetime for all foreign travel emergency care, urgently needed care services, or inpatient care	
Foreign travel (outside U.S. and its territories) Emergency Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Inpatient care** $0 copay per admission 60 days per lifetime **Maximum Benefit** $10,000 maximum benefit per lifetime for all foreign travel emergency care, urgently needed care services, or inpatient care	
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition and qualify under Special Supplemental Benefits for the Chronically Ill	Must use NationsBenefits $0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).	Reimbursed up to $5 copay for each equivalent medically tailored meal 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support	

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

This document reflects cost shares only.

† Must use the plan approved provider in-network

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage (EOC).

If you use an out-of-network provider, you may be required to pay in full at the time of service and submit a request for reimbursement. To submit a request form for reimbursement, you will need to provide proof of payment and an itemized receipt.

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Medicare & You 2027 resource: For more information, we encourage you to read Medicare & You 2027. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.gov.** Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

SilverSneakers is a registered trademark of Tivity Health. All rights reserved Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.

‡ If you use an out-of-network provider for your exam or purchase hearing aids from an out-of-network hearing aid vendor, you may be required to pay in full at the time of service and submit a request for reimbursement. To submit a request form for reimbursement, you will need to provide proof of payment and an itemized receipt.

Hearing benefit management administered by TruHearing, an independent company.

Anthem

Prescription Drug Summary of Benefits: 01/01/2027 – 12/31/2027
Formulary E4, $10/$15/$30/20% up to $200 (with Senior Rx Plus)

Santa Clara Valley Water District

About this Plan:

For comprehensive information about all the services and any limitations or exclusions, please refer to your Evidence of Coverage (EOC). Upon enrolling in the plan, you'll receive guidance on accessing your plan details online. You can conveniently view your EOC by logging into the member portal at **www.anthem.com/CA**, or you can call Member Services with any questions you may have.

How much is the monthly premium?
Contact your group plan sponsor/union for more information on your plan premium.

Prescription Drug Summary of Benefits: 01/01/2027 – 12/31/2027

Stage 1 Annual Deductible Stage

In this stage, you pay a set amount. Once you reach this amount, your plan begins to pay its share of the cost.

Deductible: $0

Stage 2 Initial Coverage Stage

CMS defined drug out-of-pocket limit: $2,400

This is what you pay for covered drugs until you reach your out-of-pocket limit. You will pay this amount or the cost of the drug, whichever is less.

Pharmacy	Standard Network Pharmacy		Mail-Order Pharmacy
	per 30-day supply (Specialty limited to a 30-day supply)	per 90-day supply (Specialty limited to a 30-day supply)	per 90-day supply (Specialty limited to a 30-day supply)
Tier 1: Generics	$10	$20	$20
Tier 2: Preferred Drugs	$15	$30	$30
Tier 3: Non-Preferred Drugs	$30	$60	$60
Tier 4: Specialty Drugs	20% $200 Max	N/A	20% $200 Max
Select Generics	$0	$0	$0

Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will pay the mail-order copay.

Stage 3 Catastrophic Coverage Stage

Your payment responsibility changes after the amount you have paid for covered drugs reaches the **CMS defined drug out-of-pocket limit** of $2,400.

Retail and Mail-Order Pharmacies	up to a 90-day supply (Specialty limited to a 30-day supply)
All Part D Covered Prescription Drugs	$0

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.

- **Important Message About What You Pay for Insulin:** You won't pay more than $35 for a one-month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare Part B medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare Part D drug coverage. Hepatitis B is covered under Medicare Part D drug coverage unless you fall into a high risk category, then it is covered under Medicare Part B medical coverage. Other common vaccines are also covered under Medicare Part D drug coverage for Medicare-eligible individuals under 65. You can fill your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office, you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to pay its share of the cost. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

- **Select Generics:** Your plan includes the $0 copay Select Generics benefit. Select Generics are a specific list of drugs that have been on the market long enough to have a proven track record for effectiveness and value. These generic drugs treat common conditions like diabetes, high blood pressure, high cholesterol, and osteoporosis. The Select Generics benefit is designed to help you better manage your chronic conditions and reduce out-of-pocket costs on prescription medications.

Extra Covered Drugs Benefits Chart

These prescription drugs are not covered under Part D, but they are provided under your Senior Rx Plus benefits. There may be instances where state regulations require these drugs to be included in your plan. These drugs do not count towards your **CMS defined drug out-of-pocket limit** of $2,400.

Pharmacy	Standard Network Pharmacy	Mail-Order Pharmacy
	per 30-day supply	per 90-day supply
Cough and Cold;DESI;Vitamins and Minerals		
Tier 1: Generics	$10	$20
Tier 2: Preferred Drugs	$15	$30
Tier 3: Non-Preferred Drugs	$30	$60
Erectile Dysfunction (ED)	**Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.**	
Tier 1: Generics	$10	$20
Tier 2: Preferred Drugs	$15	$30
Tier 3: Non-Preferred Drugs	$30	$60
Other Non-Part D Coverage		
Contraceptive Devices	$15	$15

- **Over the Counter Drugs:** To get over the counter drugs listed as covered under your drug plan, you must have a prescription from your provider and have the prescribed drug filled by the pharmacist.

This document reflects cost shares only.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.
The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Medicare & You 2027 resource: For more information, we encourage you to read Medicare & You 2027. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you

don't have a copy of this booklet, request one at www.medicare.gov. Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Common health plan terms

Here are terms you'll come across in this guide and what they mean.



Care

Facility – A location for receiving care. Examples: hospital, skilled nursing facility (SNF), or imaging center.

Inpatient care – Medical treatment for someone formally admitted to a facility with a doctor's order. Without a doctor's order, it may be considered outpatient care, even if you stay overnight.

Outpatient care – Medical treatment for someone not admitted to a facility. It may take place in a doctor's office, clinic, or hospital outpatient department.

Preventive care – Services that help you stay healthy and detect health problems early when treatment works best. Examples: exams, shots, lab tests, screenings, and programs for health monitoring, counseling, and education.

Primary care provider (PCP) – A general practice doctor, nurse practitioner, or physician assistant who treats basic medical conditions and is often the first person you'll see for health concerns. PCPs provide checkups, vaccinations, and screenings. They help diagnose conditions and refer you to specialists when needed. You are not required to select a PCP.

Care provider – A doctor, nurse, clinician, hospital, health system, licensed healthcare facility, program, agency, or healthcare professional that delivers healthcare services.



Cost

Annual out-of-pocket maximum (or max OOP) – The maximum amount you pay for medical costs each plan year. After paying the max OOP, you pay nothing for covered services until the next plan year. Copays, coinsurance, and deductibles count toward the max OOP, but not all costs do. Not all medical costs or services are included in or subject to the annual out-of-pocket maximum.

Summary of Benefits – A summarized list of medical care and drugs the plan covers.

Coinsurance – A percentage you may be required to pay for covered services or drugs after paying your deductible.

Copay – A fixed dollar amount you may be required to pay for covered services or drugs after paying your deductible.

Cost share – Also called "cost-sharing amount" or "your share of the costs." It is usually a deductible, copay, or coinsurance. This is the amount you pay for covered services or drugs.

Covered services and drugs – Medical care and drugs your plan pays for under the plan terms.

Deductible – If applicable, the fixed dollar amount you pay for medical care or drugs before the plan begins to pay.

Required information for this plan year

Your rights, protections, and Medicare options

As a Medicare beneficiary, you have many rights and options put in place to protect you as a consumer. You have choices.

As a Medicare beneficiary, you can choose between:

- The Original (Fee-for-Service) Medicare plan.
- A Medicare health plan like the one offered in this guide.

You may have other options

The important thing to remember is that the choice is yours, keeping in mind that you may be able to join or leave a plan only at certain times. Please note that if you do not take your retiree benefits, it may affect other retiree benefits your group sponsor offers. No matter what you decide, you may still be eligible for the Original Medicare program.

Geographic service areas covered by this plan

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, D.C., and all United States territories.

Your Medicare protection

The plan must offer Medicare benefits to you for a full calendar year at a time, although benefits and cost sharing may change from year to year. The plan provider can decide each year whether to keep offering Medicare Advantage plans, or whether or not to continue offering plans in specific geographic areas like yours.

Also, Medicare may decide to end our contract..

If for some reason this plan is discontinued, we will send you a letter at least 90 days before your coverage ends explaining your options for Medicare coverage in your area.

For more information on the options and rights you have as a Medicare Advantage member with this plan, please contact our RetireeFirst Member Advocate Line and ask for a copy of the Evidence of Coverage (EOC).

Extra Help from Medicare

You may be able to find help to pay for your prescription drugs and other Medicare costs. If you qualify for Medicare's Extra Help and are enrolled in a Part D plan like this one, Medicare can pay up to 100% of your prescribed drugs. This can help offset your drug plan's monthly premium, plus coinsurance and copays for covered prescription drugs.

Extra Help can also close any drug coverage gaps and stop late enrollment penalties (LEPs). For more information, visit **www.medicare.gov** or **www.ssa.gov**, or call:

- **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.
- The Social Security Administration at **1-800-772-1213**, Monday to Friday, 7 a.m. to 7 p.m. ET. TTY users should call **1-800-325-0778**.
- Your state Medicaid office.

Required information for this plan year

Information about Medicare

To help you make more informed healthcare decisions, we are providing this important information about Medicare to use as a resource. If you have any questions, please contact our RetireeFirst Member Advocate Line.

Pay your Medicare Part B premiums

Once you enroll in this plan, you must continue to pay your Medicare Part B premiums. If you don't, Medicare will terminate your coverage and then you may have to pay a late enrollment penalty if you decide to reenroll.

Enrolling in other plans

If you decide to enroll in other plans, you may be disenrolled from your current plan.

Notifying your group sponsor

To ensure a smooth enrollment, make sure your group sponsor has your most up-to-date information and that it matches your Social Security information.

Matching Medicare Advantage (medical) coverage and Part D (prescription drug) coverage for members in group plans

If you are enrolled in a group Medicare Advantage plan, your Part D coverage must also be a group Part D plan. This is important because enrolling in a non-group Part D plan could result in termination of your enrollment in your group Medicare Advantage plan.

What to know about a drug list

A drug list is a list of drugs covered by the plan. We choose our list to provide good prescription coverage and a good value to you, as well.

When new drugs come to market, we conduct a clinical and cost review and may add them to the drug list. To keep plans affordable, every year we may also remove drugs or change the cost you pay for them the following year. But don't worry, we'll notify you first and send you a new drug list when we make these changes.

Important: Check to see if your drug is on the drug list before you go to the pharmacy.

If the drug you take is not on our drug list, you will have to pay the full price of the drug. If that's the case, or if your drug comes with additional requirements or limits, you may be able to receive a temporary supply. We will notify you once the temporary supply is dispensed. You will have to contact your doctor and ask if you can switch to a different drug listed on our drug list.

About IRMAA and your income level

If your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit, you must pay an income-related monthly adjustment amount (IRMAA) in addition to your monthly plan premium.

The Social Security Administration will contact you if you have to pay an IRMAA, which you must pay to them, not us.

High-income surcharges

If you must pay a high-income surcharge on your Medicare Part B or Part D premium to the Social Security Administration, please be sure to do so to avoid a mandatory disenrollment.

Required information for this plan year

Information about Medicare

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age, or disability. For people with disabilities, we offer free aids and services. Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the number listed in this guide to request interpreter services.

Out-of-network/noncontracted providers are under no obligation to treat Anthem members, except in emergency situations. Please call our RetireeFirst Member Advocate Line at **1-855-301-8203**, TTY: **711**, Monday through Friday, 8 a.m. to 5 p.m. PT, for more information.

This information is not a complete description of benefits. Contact the plan for more information. Every year, Medicare evaluates plans based on a five-star rating system.

This guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Benefits Chart and Evidence of Coverage (EOC), which is available upon enrollment. In the event of a conflict between the Benefits Chart and EOC and this guide, the terms of the Benefits Chart and EOC documents will prevail.

Coordination of Benefits (COB) letter

If we receive Coordination of Benefits (COB) information from CMS, we are required to send a letter to you requesting verification of the other coverage information. The benefit verification letter we send will include information from CMS, including any other coverage that needs to be verified.

Separately, we could receive COB information from other reporting sources in addition to CMS.
If the information is not correct in the letter, you can call Member Services at the number listed on your ID card or you can fill in the correct information on the letter and return it to the plan for processing.

If a response is not received within 21 days, the information on the letter is considered to be accurate.

If the previous carrier does not notify CMS of the previous plan termination prior to the plan enrollment process, a COB letter could be triggered for the plan that was just terminated.

Required information for this plan year

Information about Medicare

Anthem BC Health Insurance Company is a PPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal.

Anthem Blue Cross is the trade name of In California: Blue Cross of California, Anthem Blue Cross Partnership Plan, Anthem BC Health Insurance Company and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. In 11 northeastern counties of New York: Anthem Blue Cross is the trade name of Anthem HealthChoice Assurance, Inc., and Anthem HealthChoice HMO, Inc. In these same counties Anthem Insurance Companies, Inc., dba Anthem Blue Cross Retiree Solutions and Anthem Blue Cross HP is the trade name of Anthem HP, LLC. Independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Out-of-network/noncontracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Important information regarding your plan

Release of information: By joining this Medicare Advantage with Part D prescription drug plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations.

I understand that the effective date of coverage is when I can begin using the plan services, and Anthem will send me written notification of the effective date of my enrollment in the plan. I understand that this Medicare Advantage with Part D prescription drug plan is offered under a contract with the Centers for Medicare & Medicaid Services (CMS) and the CMS review of its benefits. I understand that my coverage will come into effect only if this enrollment is approved by the plan and CMS.

I understand that I need to keep my Medicare Part A and Part B. I must maintain my Medicare Part B insurance by continuing to pay the Part B premium, if applicable.

I understand that I can be enrolled in only one Medicare Advantage or Part D prescription drug plan at a time. Enrollment in this plan will automatically end my enrollment in any other Medicare Advantage or Part D prescription drug plan. I am responsible for informing the plan of any other prescription drug coverage I have or may obtain in the future.

I understand that once my coverage begins, I must receive all medical and prescription drug benefits through Anthem. Only the benefits and services described in the Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor the plan will pay for benefits or services.**

I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the United States border.

I understand that as a member of this plan, I have the right to ask about the plan's decision regarding payments or coverage for services I receive. I also have the right to appeal plan decisions about payment or services if I disagree.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English – ATTENTION: If you need help in your language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-855-301-8203** (TTY: **711**).

Español (Spanish) – ATENCIÓN: Si necesita ayuda en su idioma, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono indicado anteriormente.

العربية (Arabic) – تنبيه: إذا كنت تحتاج إلى المساعدة بلغتك، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجانا. اتصل على رقم الهاتف المذكور أعلاه.

繁體中文 (Chinese) – 注意：如果您在您的語言方面需要協助，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打上面列出的電話號碼。

Français (French) – ATTENTION : Si vous avez besoin d'aide dans votre langue, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone mentionné ci-dessus.

Deutsch (German) – ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, stehen Ihnen kostenlose Dienste zur sprachlichen Unterstützung zur Verfügung. Außerdem sind kostenlose Hilfsmittel und Dienste verfügbar, um Informationen in zugänglichen Formaten bereitzustellen. Rufen Sie die oben aufgeführte Telefonnummer an.

ગુજરાતી (Gujarati) – ધ્યાન આપો: જો તમને તમારી ભાષામાં મદદની જરૂર છે, તો તમારા માટે વિના મૂલ્યે ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પરૂદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. ઉપર દશાર્વેલ ફોન નંબર પર કોલ કરો.

हिंदी (Hindi) – ध्यान दें: यदि आपको अपनी भाषा में सहायता चाहिए, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। पहुँच योग्य प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। ऊपर दिए गए फ़ोन नंबर पर कॉल करें।

Italiano (Italian) – ATTENZIONE: se hai bisogno di supporto nella tua lingua, sono disponibili servizi di assistenza linguistica gratuita. Sono inoltre disponibili gratuitamente adeguati supporti e servizi per ottenere informazioni in formato accessibile. Chiama il numero di telefono riportato sopra.

日本語 (Japanese) – 注意：ご使用の言語でのサポートが必要な場合には、無料の言語支援サービスをご提供しています。適切な補助器具・サービスも、利用者がアクセスしやすい方法でご提供しています。こちらも無料でご利用いただけます。

한국어(Korean) – 주의: 귀하의 언어로 도움이 필요하신 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 대체 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 위의 전화 번호로 전화해 주십시오.

Português (Portuguese) – ATENÇÃO: Se necessita de ajuda no seu idioma, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone acima indicado.

Русский (Russian) – ВНИМАНИЕ: Если вам нужна помощь на вашем языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по вышеуказанному номеру телефона.

Tagalog (Tagalog) – PAUNAWA: Kung kailangan mo ng tulong sa iyong wika, mayroong libreng serbisyo para sa iyo. Available din ang naaangkop na tulong at serbisyo na nagbibigay ng impormasyon sa iyong wika. Ito ay libre rin. Tawagan ang numero ng telepono na nakalista sa itaas.

తెలుగు (Telugu) – గమనిక: మీకు మీ భాషలో సహాయం అవసరమైతే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న ఫార్మాట్లలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు, సేవలు కూడా ఉచితంగా లభిస్తాయి. పైన పేర్కొన్న ఫోన్ నంబర్‌కు కాల్ చేయండి.

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại nêu trên.


Anthem


Valley Water