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.

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

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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.

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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.

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