

Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: Rivian and Volkswagen Group Technologies, LLC: Anthem PPO 500

Your Network: Prudent Buyer PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	\$20 copay per visit deductible does not apply
Mental Health & Substance Use Disorder Services	\$20 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$500 person / \$1,000 family	\$1,000 person / \$2,000 family
Overall Out-of-Pocket Limit	\$3,000 person / \$5,000 family	\$6,000 person / \$10,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

In-Network and Out-of-Network deductibles and out-of-pocket limit amounts accumulate toward each other.

Doctor Visits (virtual and office) You are encouraged to select a Primary Care Physician (PCP).		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$20 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Provider <i>virtual and office</i>	virtual -\$20 copay per visit deductible does not apply office -\$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Other Practitioner Visits		
Maternity services Prenatal and Postpartum care	PCP: \$20 copay per visit deductible does not apply SPC: \$30 copay per visit deductible does not apply	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Delivery Retail Health Clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	20% coinsurance after deductible is met Not covered	30% coinsurance after deductible is met Not covered
Manipulation Therapy	\$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Acupuncture	\$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs Dispensed in the office	Not covered	Not covered
Surgery	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions per IRS guidelines	No charge	Not covered
<u>Diagnostic Services</u> Lab		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Diagnostic Services</u> X-Ray		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Diagnostic Services</u> Advanced Diagnostic Imaging for example: MRI, PET and CAT scans		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care includes doctor services. Additional charges may apply depending on the care provided.	\$50 copay per visit deductible does not apply	30% coinsurance after deductible is met
Emergency Room Facility Services Your copay will be waived if admitted.	\$150 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	20% coinsurance after deductible is met \$20 copay per visit deductible does not apply	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services including surgeon fees Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services including surgeon fees	20% coinsurance after deductible is met 20% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Home Health Care</u>	20% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Therapy Services</u> Rehabilitation and Habilitation services including physical, occupational and speech therapies. Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation office and outpatient hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation office and outpatient hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 120 days per benefit period.</i>	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice <i>Coverage is limited to 360 days per lifetime.</i>	20% coinsurance deductible does not apply	30% coinsurance after deductible is met
Additional Services, Equipment and Devices		
Durable Medical Equipment	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Wigs	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Hearing Aids	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit

Prescription Drug Coverage Network: Base Network Drug List: National Direct Plus

Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.		
Tier 1 - Typically Generic	\$10 copay per prescription (retail) and \$20 copay per prescription (home delivery)	\$10 copay and then 25%(retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$30 copay per prescription (retail) and \$60 copay per prescription (home delivery)	\$30 copay and then 25%(retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$60 copay per prescription (retail) and \$120 copay per prescription (home delivery)	\$60 copay and then 25% (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	\$60 copay per prescription (retail) and \$120 copay per prescription (home delivery)	\$60 copay and then 25% (retail) and Not covered (home delivery)

Notes:

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Questions: (650) 642-1017 or visit us at www.anthem.com/ca

Intentionally Left Blank

Get help in your language

Language Assistance Services

Curious to know what all this says?

We would be too. Here's the English version: No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357 (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card

Spanish

Servicios lingüísticos sin costo. Puede solicitar los servicios de un intérprete. También puede solicitar que le leamos y le envíemos algunos documentos en su idioma. Llame al número que figura en su tarjeta de identificación o al 1-888-254-2721. Si necesita más ayuda, llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711).

Arabic

خدمات لغوية مجانية. يمكنك الحصول على مترجم فوري. يمكنك الحصول على مستندات تقرأ لك وارسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المدرج على بطاقة الهوية الخاصة بك أو 1-800-254-2721. لمزيد من المساعدة اتصل بقسم التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)

Armenian

Առանց արժեքի լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Դուք կարող եք ստանալ փաստաթղթեր, որոնք կարդում են ձեզ համար, իսկ որոշները՝ ուղարկվում են ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ID քարտով նշված համարով կամ 1-888-254-2721 հեռախոսահամարով: Լրացնից օգնության համար զանգահարեք CA Ապահովագրության բաժանմունք՝ 1-800-927-4357 (TTY/TDD: 711)

Chinese

免費語言服務。您可獲得口譯員服務。可以把文件唸給您聽，有些文件有您的語言的版本，也可以把這些文件寄給您。欲取得協助，請致電您的ID卡所列的電話號碼，或致電1-888-254-2721與我們聯絡。欲取得其他協助，請致電1-800-927-4357 (TTY/TDD: 711) 與 CA 保險部聯絡

Farsi

خدمات زبان بدون هزینه. شما می توانید مترجم شفاهی درخواست کنید. می توانید بخواهید اسناد برای شما به زبان شما خوانده شود و برخی اسناد به زبان شما برایتان ارسال شود. برای راهنمایی، با ما با شماره مندرج در کارت عضویت خود یا شماره 1-888-254-2721 تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه CA به شماره 1-800-927-4357 (TTY/TDD: 711) تماس بگیرید.

Hindi

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज अपनी भाषा में पढ़ा सकते हैं और कुछ को अपनी भाषा में खुद तक भिजवा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिए गए नंबर पर या 1-888-254-2721 पर हमें कॉल करें। अधिक सहायता के लिए सीए बीमा विभाग को 1-800-927-4357 पर कॉल करें (TTY/TDD: 711)

Hmong

Tsis Sau Nqi Rau Kev Pab Cuam Txog Lus. Koj tuaj yeem tau txais tus kws txhais lus. Koj tuaj yeem tau txais cov ntaub ntawv kom muab nyeeem rau koj mloog thiab kom muab xa rau koj ua yam lus koj hais. Rau kev pab, hu peb tus npawb xov tooj muaj nyob ntawm koj daim npav ID los sis 1-888-254-2721. Rau kev pab ntxiv hu lub CA Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)

Japanese

無料の言語サービス。通訳を頼むこともできます。文書を使用言語で読み上げたり、送信したりすることもできます。サポートが必要な場合、IDカードに記載されている電話番号または1-888-254-2721までお電話ください。さらに詳しい情報については、カリフォルニア州保険局までお問い合わせください。電話番号：1-800-927-4357 (TTY/TDD: 711)

Khmner

បចនកតកថ្លែងរកសាល់។ អ្នកអាចចិត្តលបានអ្នក
បកប្រាប់ អ្នកអាចទទួលបានឯកសារអាជីវិតអ្នក
សាប និងឯកសាល់ដើម្បីអ្នកជាការសារបែងអក។
ស្របតាមឯកសារ សូមទទួលសព្វមកយើងតាមលទ្ធផល
បាននៅក្នុងការ ID បែងអ្នក ឬ 1-888-254-2721។
ស្របតាមឯកសារបែន្ទីម សូមទទួលសព្វនៅក្នុងការ
រំបាយ CA តាមរយៈលេខ 1-800-927-4357
(TTY/TDD: 711)

Korean

무상 언어 서비스. 통역사를 연결시켜 드립니다. 문서를 귀하에게 읽어드릴 수 있고 어떤 서류는 귀하의 언어로 작성하여 맥으로 보내드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 나와 있는 번호 또는 **1-888-254-2721** 번으로 전화해 주시기 바랍니다. 더 많은 도움이 필요하시면 CA 보험부에 **1-800-927-4357** (TTY/TDD: 711)로 전화해 주십시오.

Punjabi

ਬਿਨਾ ਕੋਈ ਲਾਗਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਲੇ ਸਕਦੇ ਹੋ।
 ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ
 ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ
 ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚਿਬੰਧ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ
 1-888-254-2721. ਹੇਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ
 ਇੱਥੇ ਕਾਲ ਕਰੋ 1-800-927-4357 (TTY/TDD: 711)

Russian

Доступны бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут зачитать документы вслух, а некоторые из них могут быть отправлены вам на вашем языке. Если вам нужна помощь, позвоните нам по номеру, указанному на вашей идентификационной карте участника плана, или по номеру 1-888-254-2721. Для получения дополнительной помощи позвоните в Департамент страхования штата California по номеру 1-800-927-4357 (TTY/TDD: 711).

Tagalog

Walang Gastos na mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter. Maaari mong ipabasa ang mga dokumento sa iyo at ipadala sa iyo ang ilan sa nang nasa wika mo. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o 1-888-254-2721. Para sa higit pang tulong tumawag sa CA Dept. of Insurance sa 1-800-927-4357 (TTY/TDD: 711)

Thai

บริการด้านภาษาแบบไม่เสียค่าใช้จ่าย คุณสามารถรับคำแนะนำเพื่อช่วยเหลือได้ คุณสามารถรับเอกสารแบบมีผู้อ่านให้ฟังและส่งให้คุณในภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อเราตามหมายเลขที่ระบุบนบัตรประจำตัวของคุณหรือ 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อกองการประกันภัยแห่งแคลิฟอร์เนียได้ที่ 1-800-927-4357 (TTY/TDD: 711)

Vietnamese

Dịch vụ Ngôn ngữ Miễn Phí. Quý vị có thể
được bố trí thông dịch viên. Quý vị có thể
yêu cầu họ đọc tài liệu hoặc gửi cho quý vị
một số tài liệu bằng ngôn ngữ của quý vị.
Để được trợ giúp, hãy gọi cho chúng tôi
theo số điện thoại được ghi trên thẻ ID của
quý vị hoặc 1-888-254-2721. Để được trợ
giúp thêm, hãy gọi cho Sở Bảo hiểm CA
theo số 1-800-927-4357 (TTY/TDD: 711).

It's important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>