



Covered Medical Benefits	Cost if you use an In- Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Advanced Diagnostic Imaging for example: MRI, PET and CAT scans		
Office	\$100 copay per service	Not covered
Freestanding Radiology Center	\$100 copay per service	Not covered
Outpatient Hospital	\$100 copay per service	Not covered
Emergency and Urgent Care		
Urgent Care Copay waived if admitted.	\$20 copay per visit	Covered as In-Network
Emergency Room Facility Services  Copay waived if admitted.	\$100 copay per visit	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	No charge	Covered as In-Network
Ambulance	\$100 copay per trip	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	\$20 copay per visit	Not covered
Facility Visit		
Facility Fees	No charge	Not covered
Doctor Services	No charge	Not covered
Outpationt Surgery		

**Outpatient Surgery** 

Facility Fees

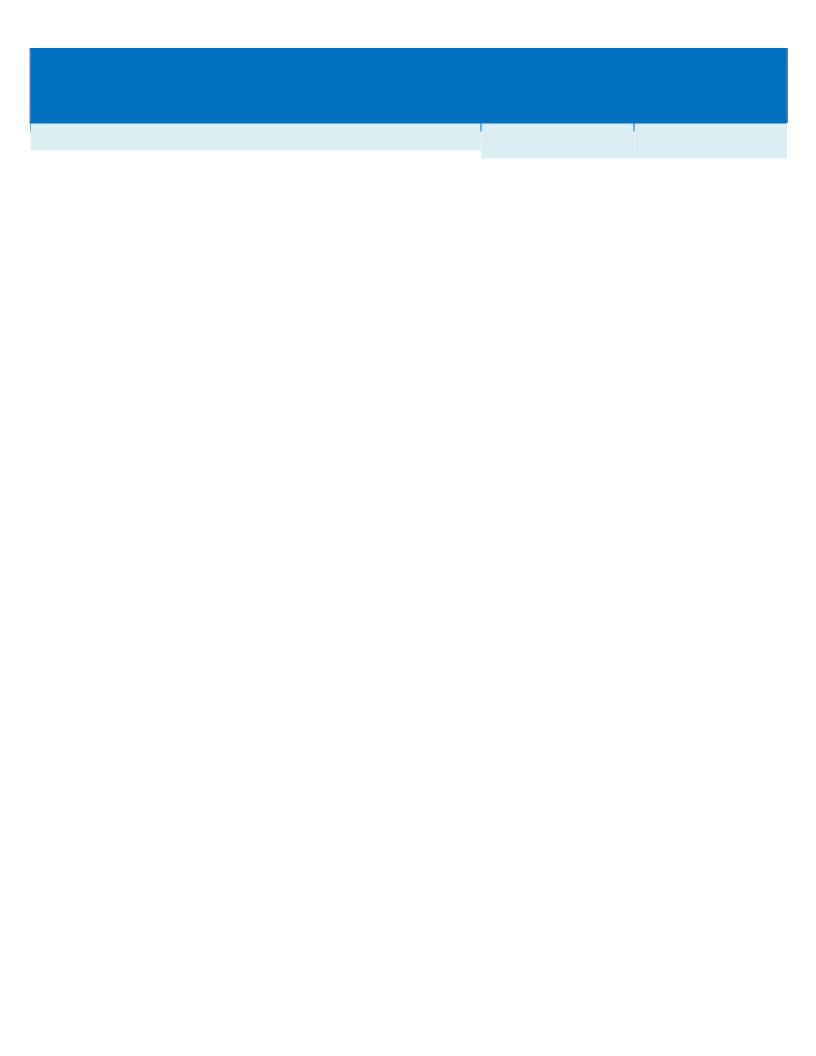
Hospital \$100 copay per

Freestanding Surgical Center

**Doctor and Other Services** 

Hospital

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- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- 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 HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Your Plan: PRISM (CSURMA): Custom Premier HMO 20/200 admit/100 OP- California Care HMO

Your Network: California Care HMO

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of

## Get help in your language



**Language Assistance Services** 

Curious to know what all this say

، هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الأسند من بسراً خص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. صول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم2721-888-1 (TTY/TDD:711).

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मदत्नपूर्णा, भाषा, क्ष्मिष्टि यद प्रकृते और क्षेत्र प्रकृते और काला प्राप्त काला प्राप्त प्रकृत प्राप्त के किया कियी को उप यहरा 重要:この書簡を読めますか?もし読めない場合には

សំខាន់៖ តើអ្នករាចសាខលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យនយោម្នាក់អានវាជុនអ្នក។ អ្នកកំរាចទន្ទរលិខិតនេះដោយស<sup>្តា</sup>្ត្រមករាសរបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្ងៃ សូមហៅទូស័ព្ទភ្លាម១ទៅលេខ 1-888-25

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