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

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م: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاندماج. يتم إخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. بصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD:711).

ما در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت نوشتاری دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 (TTY/TDD:711) تماس بگیرید.

महन्तपार्क, न्यूयार्क, भाषा. जहाँ से मदद मंगाने है। अगर आपको यह जानकारी चाहिए है तो कृपया 1-888-254-2721 (TTY/TDD:711) पर कॉल करें।



重要：この書簡を読めますか？もし読めない場合には

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