
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
Emergency Room Doctor and Other Services	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
Outpatient Surgery		
Facility Fees		
Hospital	$100 copay per	
Freestanding Surgical Center		
Doctor and Other Services		
Hospital		

- **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

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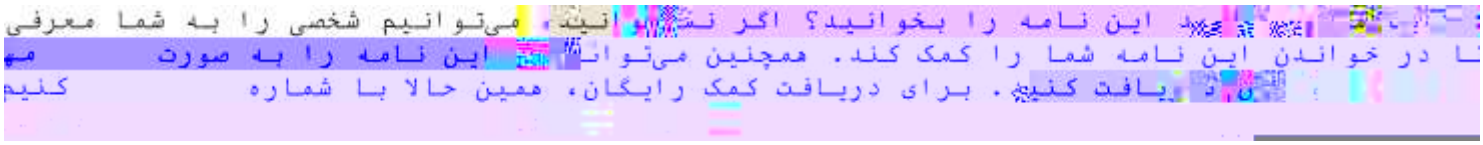
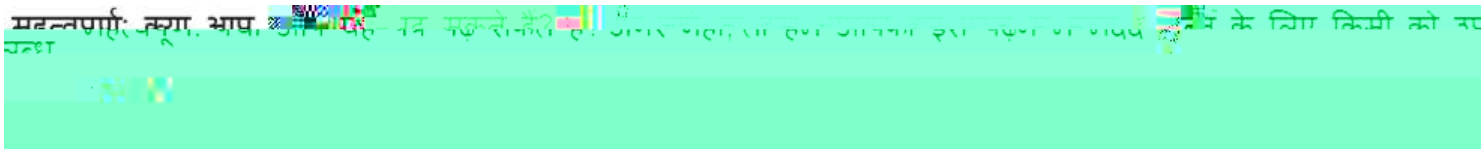
Curious to know what all this say





重要：この書簡を読めますか？もし読めない場合には

online at _____