Thrill-seeker

Anthem Health. Join In.

- $20 copay
- $5,000 deductible

Current as of September 23, 2010. Benefits subject to change.

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Tonik℠ for Individuals $5,000

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. DEDUCTIBLE TYPE[2]	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a] a) Individual[2b]	$5,000 per calendar year which is the out-of-pocket maximum for in-network providers and applies to your out-of-pocket maximum, combined in-network and out-of-network. The first four office visits, emergency room visits, ambulance services, certain routine vision benefits and certain preventive care services are not subject to your deductible. Some copayments and coinsurance will not be applied to your deductible.	$5,000 per calendar year which applies to your out-of-pocket maximum for out-of-network providers, combined in-network and out-of-network. The first four office visits, emergency room visits, ambulance services, certain routine vision benefits and certain preventive care services are not subject to your deductible. Some copayments and coinsurance will not be applied to your deductible.
b) Family[2c]	Family coverage not provided	Family coverage not provided

Questions? Visit www.Medicoverage.com or call 800-930-7956

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

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06-00496 (9/10)

	IN-NETWORK	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] a) Individual	$5,000 which is your deductible amount per calendar year, some copayments and coinsurance will not be applied toward your out-of-pocket annual maximum, for these services you will continue to pay copayments and coinsurance even after you out-of-pocket annual maximum has been satisfied. See policy for types and circumstances of coverage.	$10,000 per calendar year, some copayments and coinsurance will not be applied toward your out-of-pocket annual maximum, for these services you will continue to pay copayments and coinsurance even after you out-of-pocket annual maximum has been satisfied. See policy for types and circumstances of coverage.
b) Family	Family coverage not provided	Family coverage not provided
c) Is deductible included in the out-of-pocket maximum?	Yes	Yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime limits. For benefit limits please see each applicable benefit below.	
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO Provider Network. See provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes

	IN-NETWORK	OUT-OF-NETWORK
8. MEDICAL OFFICE VISITS[4]		
a) Primary Care Providers	$20 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year.	40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year.
b) Specialists	$20 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year.	40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year.

9. PREVENTIVE CARE a) Children's services	Preventive Care Services shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the covered member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration	\$20 copayment per office visit for: Early intervention services, preventive services and immunizations (including the cervical cancer vaccination) pursuant to the schedule established by the Advisory Committee on Immunization Practices. Child health supervision services shall be provided up to age 13. Child health supervision services shall be exempt from a deductible or dollar limit provision. Copayments and coinsurance may be imposed for child health supervision services, but they shall not exceed the copayment or coinsurance payment, as applicable, to a physician visit. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. 40% coinsurance for all other covered preventive care services

b) Adults' services	Preventive Care Services shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the covered member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration	$20 copayment per office visit for: Routine cytological screening (pap test), mammography benefit in accordance with Colorado law, colorectal cancer examination and related laboratory tests, cholesterol screening, immunizations against cervical cancer, influenza and pneumococcal vaccinations, alcohol misuse and tobacco use screening and behavioral counseling or cessation interventions, and prostate cancer screening. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. 40% coinsurance for all other covered preventive care services

	IN-NETWORK	OUT-OF-NETWORK
10. MATERNITY		
a) Prenatal care	Not covered	Not covered
b) Delivery & inpatient well baby care[5]	Delivery not covered, this plan only covers complications of pregnancy. No copayment; 100% covered after deductible for inpatient well baby care for 31-days following birth, adoption or placement for adoption.	Delivery not covered, this plan only covers complications of pregnancy. 40% coinsurance after deductible for inpatient well baby care for 31-days following birth, adoption or placement for adoption.
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions		
a) Outpatient care	Generic formulary drugs $10 copayment or 30% of the negotiated fee for self-injectable drugs at a participating pharmacy up to a 34-day supply. Prescription generic drugs listed on the formulary are covered.	Not covered
b) Prescription Mail Service	Generic formulary drugs $20 copayment or 30% of the negotiated fee for self-injectable drugs through the mail order service up to a 90-day supply. Prescription generic drugs listed on the formulary are covered. For drugs on our approved list, contact Customer Service at 1-800-317-9818. Covered only when received from a participating pharmacy.	Not covered
12. INPATIENT HOSPITAL	No copayment; 100% covered after deductible	40% coinsurance after deductible
13. OUTPATIENT/AMBULATORY SURGERY	No copayment; 100% covered after deductible	40% coinsurance after deductible
14. DIAGNOSTICS		
a) Laboratory & x-ray	No copayment; 100% covered after deductible	40% coinsurance after deductible
b) MRI, nuclear medicine and other high-tech services	No copayment; 100% covered after deductible	40% coinsurance after deductible
15. EMERGENCY CARE[7,8]	$100 copayment per visit, not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum).	$100 copayment per visit not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum).

	IN-NETWORK	OUT-OF-NETWORK
16. AMBULANCE	$100 copayment per day for ground and/or air ambulance services, not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum).	$100 copayment per day for ground and/or air ambulance services, not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum).
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$20 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, routine medical office visits, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year, see line 8.	40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, routine medical office visits, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year, see line 8.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Biologically-Based Mental Illness Care is paid as Other Mental Health Care, see line 19.	Biologically-Based Mental Illness Care is paid as Other Mental Health Care, see line 19.
19. 0THER MENTAL HEALTH CARE		
a) Inpatient care	No copayment; 100% covered after deductible.). Benefits are limited to a maximum of 30 days per calendar year combined in-network and out-of-network.	40% coinsurance after deductible. Benefits are limited to a maximum of 30 days per calendar year combined in-network and out-of-network.
b) Outpatient care	No copayment; 100% covered after deductible. Benefits are limited to 20 visits per calendar year combined in-network and out-of-network.	40% coinsurance after deductible. Benefits are limited to 20 visits per calendar year combined in-network and out-of-network.
20. ALCOHOL & SUBSTANCE ABUSE	Not covered	Not covered

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	No copayment; 100% covered after deductible. Benefits are limited to 12 visits per calendar year for physical therapy, occupational therapy and/or chiropractic therapy in-network and out-of-network combined. Benefits are limited to 50 visits per calendar year for speech therapy when following surgery, injury or non-congenital organic disease, in-network and out-of-network combined. For members up to age 6 with congenital defects and birth abnormalities see the policy for types and circumstance of coverage.	40% coinsurance after deductible. Benefits are limited to 12 visits per calendar year for physical therapy, occupational therapy and/or chiropractic therapy in-network and out-of-network combined. Benefits are limited to 50 visits per calendar year for speech therapy when following surgery, injury or non-congenital organic disease, in-network and out-of-network combined. For members up to age 6 with congenital defects and birth abnormalities see the policy for types and circumstance of coverage.
22. DURABLE MEDICAL EQUIPMENT	No copayment; 100% covered after deductible. See policy for types and circumstances of coverage. For prosthetic devices (arms and legs), benefits are at least equal to those benefits provided under federal law for health insurance for the aged and disabled, if applicable..	40% coinsurance after deductible. See policy for types and circumstances of coverage. For prosthetic devices (arms and legs), benefits are at least equal to those benefits provided under federal law for health insurance for the aged and disabled, if applicable.
23. OXYGEN	No copayment; 100% covered after deductible.	40% coinsurance after deductible
24. ORGAN TRANSPLANTS	Inpatient – No copayment; 100% covered after deductible Outpatient - $20 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, routine medical office visits, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year, see line 8.	Inpatient - 40% coinsurance after deductible Outpatient – 40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, routine medical office visits, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year, see line 8.
25. HOME HEALTH CARE	No copayment; 100% covered after deductible. Benefits are limited to 60 visits per calendar year in-network and out-of-network combined.	40% coinsurance after deductible. Benefits are limited to 60 visits per calendar year in-network and out-of-network combined.

	IN-NETWORK	OUT-OF-NETWORK
26. HOSPICE CARE	No copayment; 100% covered after deductible.	40% coinsurance after deductible.
	A benefit period is 91 days. Anthem will cover up to 91-days for routine home care services per benefit period up to three benefit periods, in- and out-of-network combined. Please see the Hospice section in your certificate for a description of covered services.	
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered
28. DENTAL CARE	Dental benefits included in this plan can be found on the separate Dental Summary Plan Description.	
29. VISION CARE	Reimbursement of up to $50 per calendar year not subject to deductible for such services as routine eye exam, eyeglasses or contact lenses, in-network and out-of-network combined. See the separate Vision Summary Plan Description for additional vision benefits included in this plan.	Reimbursement of up to $50 per calendar year not subject to deductible for such services as routine eye exam, eyeglasses or contact lenses, in-network and out-of-network combined. See the separate Vision Summary Plan Description for additional vision benefits included in this plan.
30. CHIROPRACTIC CARE	See line 21.	See line 21.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Program to Stop Tobacco Use: We will cover smoking cessation programs designed to end the dependence on nicotine as determined by federal and state law. Covered benefits apply to in network services only. Second Opinion: Members who desire another professional opinion, may obtain a second surgical opinion. Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams (No coinsurance after deductible). Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefits and subject to the prescription copayment.	Program to Stop Tobacco Use: Not covered. Second Opinion: Members who desire another professional opinion, may obtain a second surgical opinion. Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams (40% coinsurance after deductible). Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefits and subject to the prescription copayment.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law or under age 19, in which case there are no pre-existing condition exclusions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	Yes, unless the individual is a HIPAA-eligible individual as defined under federal and state law.

34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	For members age 19 and older, a pre-existing condition is an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health-care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan, sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, the member is responsible for obtaining prior authorization unless the provider participates with Anthem Blue Cross and Blue Shield. If prior authorization is not obtained the member is responsible for an additional $250 copayment for services from a non-participating provider. This $250 copayment does not apply to your out-of-pocket annual maximum.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining the prior authorization.	Yes, the member is responsible for obtaining prior authorization unless the provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield Non-Participating Providers have not signed agreements with Anthem. You will pay a much greater share of the cost for covered services when you receive services from them. They may charge you whatever they like, but we will pay benefits based only on the amount we that we will allow for non-participating providers which is subject to the Maximum Allowed Amount. You will be responsible for any balance of a non-participating provider's bill which is above the Maximum Allowed Amount for non-participating providers, in addition to any other copayments, coinsurance and deductible.
39. What is the main customer service number?	1-800-317-9818	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 1-800-317-9818	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #' 06-00496, individual	
43. Does the plan have a binding arbitration clause?	Yes	

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement."

[2a] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

[2b] "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

[4] Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother if complication of pregnancy and well-baby together: there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[7] "Emergency care" means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.

[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

WHAT IS NOT COVERED

We will not furnish benefits for the following services and supplies. They are considered to be exclusions and limitations, which include, but are not limited to the following:

ACUPUNCTURE AND ACCUPRESSURE

ALCOHOL ABUSE
For detoxification or rehabilitation without regard to where the service is performed or the services provided.

ALTERNATIVE OR COMPLEMENTARY MEDICINES
Services in this category include holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reike therapy, herbal medicine, vitamin or dietary products or therapies, natuorpathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique, clonics or iridology.

BIOFEEDBACK

BREAST REDUCTION
Breast reduction surgery (reduction mammoplasty) or services related to breast reduction surgery, unless the breast reduction surgery is performed because of breast cancer.

COMPLICATIONS OF NON-COVERED SERVICES
Complications arising from non-Covered Services and supplies. Examples of non-Covered Services include but are not limited to, Cosmetic Surgery, sex-change operations and procedures, which are determined to be Experimental/Investigational.

COSMETIC SURGERY
or other services that are performed to alter or reshape normal structures of the body in order to improve appearance.

CUSTODIAL CARE
or domiciliary or rest cures for which facilities and/or services of a general acute Hospital are not medically required. Custodial Care is care that does not require the regular services of trained medical or health professionals, such as but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets and supervision of medications which are ordinarily self-administered.

DIAGNOSTIC ADMISSIONS
Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

EDUCATIONAL SERVICES AND NUTRITIONAL COUNSELING
except as specifically covered or arranged by us under the Diabetes Outpatient Self-Management Training Program, Home Health Care, and Hospice provisions in the PART called WHAT IS COVERED.

EXCESS AMOUNTS
Any amounts in excess of the maximum amounts stated in the benefit sections of this Policy. Any amounts in excess of Maximum Allowed Amount.

EXPERIMENTAL OR INVESTIGATIONAL
Medical, surgical and/or other procedures, services, products, drugs or devices (including implants), which are Experimental and Investigational Procedures.

FOREIGN CLAIMS
This coverage does not cover claims incurred in a foreign country except claims for the initial treatment of a medical emergency or urgent condition.

GENETIC TESTING OR COUNSELING
Preconception, paternity testing, court-ordered genetic counseling and testing, testing for inherited disorders, discussion of family history or testing to determine the sex or physical characteristics of an unborn child.

GOVERNMENT SERVICES
Any services provided by a local, state or federal government agency.

HEALTH CLUB MEMBERSHIPS
This coverage does not cover health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

HEARING AIDS
Hearing aids and routine hearing tests unless specified to be covered under federal or state law.

ILLEGAL CONDUCT
All services for illness or injuries resulting in wholly or partially from conduct attributable to a crime or other violation of law.

INFERTILITY SERVICES
All services related to the evaluation or treatment of Infertility, including all tests, consultations, medications, surgical, medical or laboratory procedures.

INTRACTABLE PAIN OR CHRONIC PAIN
This coverage does not cover services or supplies for the treatment of Intractable Pain and/or chronic pain. Chronic pain is pain of continuous and long-standing duration where the cause cannot be removed.

LEARNING OR BEHAVIORAL THERAPIES

MATERNITY/PREGNANCY CARE
No benefits are covered for pregnancy, maternity care or elective or therapeutic abortions, except as specifically stated in the section Complications of Pregnancy in the PART called WHAT IS COVERED.

MEDICAL EQUIPMENT AND SUPPLIES
Including but not limited to orthopedic shoes or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, supplies for comfort, hygiene or beautification, disposable sheaths and supplies, correction appliances or support appliances and supplies such as stockings except as specifically stated in the PART called WHAT IS COVERED.

MENTAL HEALTH CARE
Treatment of Mental Health Care or psychological testing except as specifically stated under the benefit sections (for Mental Health Care) in this Policy. However, medical services provided to treat medical conditions that are caused by behavior of the Policyholder that may be associated with mental or nervous conditions, for example, self-inflicted injuries, are not subject to these limitations.

NON-DUPLICATION OF MEDICARE
We will not provide benefits that duplicate any benefits you would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which you can enroll without paying additional premium. However, if you have to pay an additional premium to enroll in Part A, B, C, or D of Medicare this exclusion will apply to that particular Part of Medicare for which you must pay only if you have enrolled in that Part.

If you have Medicare, your Medicare coverage will not affect the services covered under this Policy, except as follows:

1. Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and under this Policy.
2. If you receive a service that is covered both by Medicare and under this Policy, our coverage will apply only to the Medicare deductibles, coinsurance and other charges for Covered Services that you must pay over and above what's payable by your Medicare coverage.
3. For a particular claim, the combination of Medicare benefits and the benefits we will provide under this Policy for that claim will not be more than the allowed Maximum Allowed Amount you have incurred for the Covered Services you received.

We will apply toward your Deductible any expenses paid by Medicare for services covered under this Policy, except for expenses paid under Medicare Part D.

The Policyholder who is Medicare disabled and/or 65 years of age or older may apply for an Anthem Colorado Plan which supplements Medicare benefits. SERVICES, BENEFITS AND PREMIUMS UNDER A MEDICARE SUPPLEMENT PLAN WILL NOT BE THE SAME AS THOSE PROVIDED UNDER THIS POLICY.

NONMEDICAL EXPENSES

NOT COVERED BEFORE YOUR EFFECTIVE DATE OR AFTER YOUR COVERAGE ENDS
Services received before your Effective Date or during an inpatient stay that began before your Effective Date. Services received after your coverage ends except as provided under the PART called WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE.

NOT MEDICALLY NECESSARY
Any services or supplies that are:

- not Medically Necessary,
- not specifically described in this Policy, and
- part of a treatment plan for non-Covered Services or which are required to treat medical conditions which are a direct and predictable complication or consequence of non-Covered Services.

NUTRITIONAL AND/OR DIETARY SUPPLEMENTS
This coverage does not cover nutritional and/or dietary supplements, except as provided in this certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

ORTHOPEDIC SHOES
except when joined to braces or shoe inserts.

OTHER DENTAL SERVICES
Dentures, bridges, crowns, caps, clasps, habit appliances, partials or other dental prostheses, Dental Services, extractions of teeth or treatment to the teeth or gums, except as specifically stated for dental care under the benefit sections of this Policy. Dental Implants (materials implanted into or on bone or soft tissue) or any associated procedure as part of the implantation or removal of implants. Orthodontic Services, braces, and other orthodontic appliances, except as specifically provided or arranged by us under the sections called Dental Services Under This Policy and Cleft Palate and Cleft Lip Conditions in the PART called WHAT IS COVERED.

OTHER VISION CARE AND CERTAIN EYE SURGERIES
Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, routine eye refractions, and certain eye surgeries or any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia), except as specifically stated under the Vision sections in the PARTS called BENEFITS SUMMARY and WHAT IS COVERED and as stated in the vision section.

OUTDOOR TREATMENT PROGRAMS

OUTPATIENT DRUGS AND MEDICATIONS NOT FROM A PHARMACY
Any Drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated under the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.

OUTPATIENT SPEECH THERAPY
Except following surgery, injury, congenital defects, birth abnormalities, or non-congenital organic disease as specifically described in this Policy.

OVER THE COUNTER PRODUCTS
Items available without a prescription including bandages, thermometers, home test kits like pregnancy tests and HIV test kits.

PERSONAL COMFORT ITEMS
Items which are furnished primarily for your comfort or convenience. Air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for comfort, hygiene or beautification.

PRE-EXISTING CONDITIONS
For members age 19 and older, no payment will be made for services or supplies for the treatment of a Pre-existing Condition during a period of twelve (12) months following your Effective Date. However, we may apply Creditable Coverage to satisfy or partially satisfy the twelve (12) month period if the length of time between the ending date of your prior coverage and your Effective Date under this Policy did not exceed ninety (90) days.

PRIVATE DUTY NURSING
Inpatient or outpatient services of a private duty nurse unless we determine in advance that such services are Medically Necessary or as specifically covered under the PART called WHAT IS COVERED.

ROUTINE PHYSICAL EXAMS
or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except when covered during Office Visits as described in the Office Visits section under the PART called BENEFITS SUMMARY.

REVERSAL OF STERILIZATION

This coverage does not cover services to reverse voluntarily induced sterility,

SERVICES FOR SOMEONE OTHER THAN THE POLICYHOLDER
Any person other than the Policyholder, including but not limited to the Policyholder's dependents, such as spouse, domestic partner, legal ward, natural child, adopted child and/or newborn child (except for the first 31 days following birth, adoption or placement for adoption).

SERVICES FOR WHICH YOU ARE NOT LEGALLY OBLIGATED TO PAY
or for which no charge would be made if you did not have a health plan or insurance coverage.

SERVICES FROM RELATIVES
Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.

SEX CHANGE
Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.

SEXUAL DYSFUNCTION
Services or prescriptions for the treatment of sexual dysfunction or impotence.

SKILLED NURSING FACILITY CARE

SUBSTANCE ABUSE
For detoxification or rehabilitation without regard to where the service is performed or the services provided.

SURROGATE MOTHER SERVICE
This coverage does not cover any services or supplies provided to a person not covered under this certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

TELEPHONE, FACSIMILE MACHINE OR WEB CONSULTATIONS

TRANSPORTATION
Commercial transport (air or ground), private aviation, or air taxi services, transportation by private automobile commercial or public transportation or wheelchair ambulance. Ambulance transport if the Policyholder could have been transported by automobile, commercial or public transportation without endangering their health or safety.

UNLISTED SERVICES
Services not specifically listed in this Policy as Covered Services.

WEIGHT-LOSS PROGRAMS
This coverage does not cover weight loss programs whether or not they are pursued under medical or physician supervision. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

WORKERS' COMPENSATION
Any condition for which benefits are recovered or can be recovered either by any workers' compensation law or similar law even if you do not claim those benefits except for corporate officers who may opt out of Workers' Compensation coverage. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to Workers' Compensation law or similar law, we will provide the benefits of this plan subject to a conditional claims payment during an appeal process if a reimbursement agreement is signed.

Individual Tonik PPO Dental Summary Plan Description

Anthem

This is not a contract, it is only a summary. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the Anthem Blue Cross and Blue Shield Individual Tonik PPO Dental policy to the extent Anthem concludes there is a conflict between this document and the policy that cannot be reconciled the terms of the policy shall control.

For a covered dental service, this coverage will pay the applicable percentage or specified dollar amount (shown in the "Plan Pays (Maximum Allowable Amount)" column) of the Anthem Blue Cross and Blue Shield Dental maximum allowable for that service (up to the Yearly Maximum Benefit) assuming Medical Necessity writing period and/or applicable exclusions do not otherwise impact such coverage. Please contact customer service to verify your dental coverage.

BENEFITS WILL BE PROVIDED ONLY FOR THE COVERED SERVICES SPECIFIED IN THIS SUMMARY OF BENEFITS. NO BENEFITS WILL BE PROVIDED FOR ANY OTHER SERVICES.

Annual Policyholder Deductible	$25 combined for Network and Non-network Dentists

COVERED SERVICES		Plan Pays (Maximum Allowable Amount)	
		Network Dentists	Non-Network Dentists
Yearly Maximum Benefit		$500 combined for Network and Non-network Dentists	
	Diagnostic and Preventive Care *(Deductible Waived For In Network)*		
Procedure	Description		
*D0120	Periodic Oral Exam	100%	$18
*D0140	Limited Oral Exam-Problem Focused	100%	$28
*D0150	Initial Oral Exam	100%	$25
*D0160	Detailed and Extensive Oral Exam - new or established patient	100%	$49
*D0170	Re-evaluation Exam - Limited, Problem Focused	100%	$28
*D0180	Comprehensive Periodontal Exam - new or established patient	100%	$28
**D0210	Full Mouth X-rays	100%	$60
D0220	Single (Periapical) X-rays -- First Film	100%	$13
D0230	Single X-rays -Additional Films	100%	$8
D0240	Single X-rays - Occusal	100%	$17
D0250	Extraoral - First Film	100%	$16
D0260	Extraoral - Each Additional Film	100%	$10
D0270	Bitewing X-ray Single Film	100%	$16
D0272	Bitewing X-rays- Two Films	100%	$18
D0274	Bitewing X-rays - Four Films	100%	$26
D0277	Vertical Bitewing Xrays	100%	$16
**D0290	Posterior-Anterior or Lateral Skull and Facial Bone Survey Film	100%	$50
**D0330	Panoramic X-ray	100%	$36
**D0340	Cephalometric Film	100%	$38
D1110	Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	100%	$39
D1120	Prophylaxis (teeth cleaning child-through age 18) (limited to 2 per Year)	100%	$30
D1201	Prophylaxis (teeth cleaning child-through age 18) with fluoride (limited to 2 per Year)	100%	$35
D1203	Topical fluoride only (child through age 18) (limited to 2 per Year)	100%	$14
D1205	Topical fluoride with Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	100%	$39

* Exams are limited to two per Year.

** Full mouth X-rays or its equivalent are limited to one set every three (3) Years.

Covered Services		Plan Pays (Maximum Allowable Amount)	
		Network Dentists	Non-Network Dentists
Fillings *(Deductible Applies)*			
Procedure	Description		
D2140	Amalgam Filling -One Surface Permanent or Primary	80%	$42
D2150	Amalgam Filling -Two Surfaces Permanent or Primary	80%	$55
D2160	Amalgam Filling -Three Surfaces Permanent or Primary	80%	$72
D2161	Amalgam Filling- 4 or more surfaces, Permanent or Primary	80%	$84
D2330	Resin-Based Composite Filling-One Surface, Anterior	80%	$42
D2331	Resin-Based Composite Filling --Two Surfaces, Anterior	80%	$55
D2332	Resin-Based Composite Filling -Three Surfaces, Anterior	80%	$72
D2335	Resin-Based Composite Filling Four-Surfaces Incisal	80%	$84
D2390	Resin-Based Composite Crown, Anterior	80%	$85
***D2391	Resin-Based Composite Filling -One Surface Posterior	80%	$42
***D2392	Resin-Based Composite Filling - Two Surfaces Posterior	80%	$55
***D2393	Resin-Based Composite Filling - Three Surfaces Posterior	80%	$72
***D2394	Resin-Based Composite Filling - Four Surfaces Posterior	80%	$84
All Other Services		Not covered	Not covered

*** If a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspids.

Anthem Blue Cross and Blue Shield Dental Customer Service: (888) 209-7852

WHAT IS NOT COVERED

No benefits are provided for or in connection with the following. They are considered to be exclusions and limitations, which include, but are not limited to the following:

ALL HOSPITAL COSTS AND ANY ADDITIONAL FEES CHARGED BY THE DENTIST FOR HOSPITAL TREATMENT.

CHARGES FOR TREATMENT BY OTHER THAN A LICENSED DENTIST, except charges for dental prophylaxis performed by a licensed dental hygienist.

CLINICAL RESEARCH: Services or supplies which are part of clinical research unless We otherwise allow.

COMPLICATIONS OF NON-COVERED SERVICES: Complications arising from non-Covered Services and supplies. Examples of non-Covered Services include but are not limited to, CosmeticError! Bookmark not defined. Surgery, operations and procedures which are determined to be Experimental/Investigational.

CORRECTION OF CONGENITAL OR DEVELOPMENT MALFORMATION including but not limited to supernumery and/or over retained deciduous teeth, cleft palate, maxillary or mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).

COSMETIC DENTISTRY: Any services performed for cosmetic purposes (including but not limited to external bleaching, bleaching of non-vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth).

DIAGNOSIS OR TREATMENT OF THE JOINT OF THE JAW AND/OR OCCLUSION: Services, supplies or appliances provided in connection with:

1. Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means; or
2. Any treatment, including crowns, and/or bridges to change the way the upper and lower teeth meet (occlusion); or
3. Treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down due to attrition, abrasion, abfraction, erosion or bruxism.

END OF COVERAGE: Services received after your coverage ends.

EXCESS AMOUNTS: Any amounts in excess of the maximum amounts stated in the PART called WHAT IS COVERED.

EXPENSES BEFORE COVERAGE BEGINS: Services received before your Effective Date or during an inpatient stay that began before your Effective Date.

EXPERIMENTAL/INVESTIGATIONAL. Services or supplies which are Experimental/Investigational or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Anthem.

FILLINGS EXCEEDING ONE PER YEAR PER SURFACE PER TOOTH if you are under the age of 19 and one every three (3) Years per surface per tooth if you are over the age of 19.

FLOURIDE APPLICATIONS:

- if you are over eighteen (18) years of age.
- exceeding two visits per Year.

GOVERNMENTAL SERVICE: Any services provided by a local, state, county or federal government agency including any foreign government.

IF A TOOTH OR TEETH CAN BE RESTORED WITH AMALGAM (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspids.

IMPLANTS: (Materials implanted into or on bone or soft tissue), or the removal of implants are not benefits under this Policy.

MALIGNANCIES AND NEOPLASMS: Services for treatment of malignancies and neoplasms are not Covered Services.
Any amounts which exceed the MAXIMUM ALLOWABLE AMOUNT as determined by Anthem.

MORE THAN ONE SET OF FULL-MOUTH X-RAYS OR ITS EQUIVALENT IN A THREE (3) YEAR PERIOD.

ORAL EXAMINATIONS EXCEEDING TWO VISITS PER YEAR.

ORAL HYGIENE INSTRUCTION.

ORTHODONTIC SERVICES, braces appliances and all related services.

OVER THE COUNTER PRODUCTS: Items available without a prescription.

PERIAPICAL AND BITE WING X-RAYS SUBMITTED SINGLY will be combined and paid up to the amount of a full mouth series and are subject to the full-mouth x-ray limitation. No more than two (2) bite wing x-ray series for standard in a Year will be covered. No more than eight (8) films for vertical bite wings in a 36 month period will be covered.

PRESCRIBED DRUGS, PRE-MEDICATION OR ANALGESIA (INCLUDING NITROUS OXIDE) ARE EXCLUDED.

PROCEDURES REQUIRING RESTORATIONS (other than those for replacement of structure loss from tooth decay) that are necessary to alter, restore or maintain occlusions. These include but are not limited to:

1. Changing the vertical dimension.
2. Replacing or stabilizing lost tooth structure by attrition, abrasion, abfraction, erosion or bruxism.
3. Realignment of teeth.
4. Gnathological recording.
5. Occlusal equilibration.
6. Periodontal splinting.

PROPHYLAXIS (teeth cleaning) exceeding two treatments per Year.

REPLACEMENT OF EXISTING FILLINGS for any purpose other than restoring active decay.

SEALANTS.

SERVICES FOR ENDODONTICS, for example, root canals. Endodontics means the branch of dentistry dealing with diseases of the tooth pulp.

SERVICES FOR ORAL SURGERY, for example, tooth extractions.

SERVICES FOR PERIODONTICS, for example, scaling and root planning. Periodontics is the dental specialty of treating periodontal disease.

SERVICES FOR PROSTHODONTICS for example, crowns. Prosthodontics is the branch of dentistry dealing with the construction of artificial appliances for the mouth, especially for the purpose of replacing missing teeth with bridges and dentures.

SERVICES FOR SOMEONE OTHER THAN THE POLICYHOLDER: Any person other than the Policyholder, including but not limited to the Policyholder's dependent's such as spouse, domestic partner, legal ward, natural child, adopted child or child placed for adoption (except following birth, adoption or placement for adoption for the first thirty-one (31) days of coverage.

SERVICES FOR WHICH YOU ARE NOT LEGALLY OBLIGATED TO PAY: Services for which no charge is made to you in the absence of insurance coverage.

SERVICES FROM RELATIVES: Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.

SERVICES OR SUPPLIES THAT ARE NOT MEDICALLY NECESSARY.

SPACE MAINTAINERS. Space maintainers are appliances that are designed to prevent tooth movement.

TRANSFER OF CARE: If a Policyholder transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, Anthem shall be liable only for the amount it would have been liable for had one Dentist rendered the services.

UNLISTED SERVICES: Services not specifically listed in the Benefit Schedule section of this Policy.

WORKERS' COMPENSATION: Any condition for which benefits are recovered or can be recovered, either by any workers' compensation law or similar law even if you do not claim those benefits, except for corporate officers who may opt out of Workers' Compensation coverage. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to worker's compensation law or similar law, We will provide the benefits of this plan for such conditions, subject to a conditional claims payment during an appeal process if a reimbursement agreement is signed.

Tonik Blue View Vision Summary Plan Description

Anthem

This Summary Plan Description outlines the vision benefits available to you through the Blue View Vision Plan. This is a summary of your vision benefits; it is not a contract. Vision care benefits are intended to cover only corrective eyewear. Please review your benefit policy for plan details. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the Anthem Blue Cross and Blue Shield Tonik Blue View Vision Policy to the extent Anthem concludes there is a conflict between this document and the policy that cannot be reconciled the terms of the policy shall control.

This is a primary vision care benefit and is intended to cover only routine vision eyewear. No benefits are provided for other services. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the Plan Design. In addition, benefits are payable only for expenses incurred while the individual member coverage is in force.

Anthem's Blue View Vision Participating Provider Network: Anthem members have access to over 40,000 provider locations nationwide. Members may call Blue View Vision toll-free (866) 723-0515 or visit www.tonikhealth.com any time for provider locations. Schedule an appointment with your Blue View provider; identify yourself as a Blue View Vision member for fast, paperless determination and confirmation of benefits. Maximum benefits are achieved when members access their benefits from a Blue View Vision Participating Provider. Copayment(s) may apply to in-network benefits.

Non-Blue View Vision Provider Reimbursements: Members may go to a non-participating (non-network) provider and pay the provider directly for services and materials. Members may then submit an original itemized invoice and a copy of the prescription along with the Member's I.D. number to Blue View Vision for reimbursement according to the Non-Network Reimbursement schedule identified in this Tonik Blue View Vision Summary Plan Description.

Value Added Savings: Blue View Vision Providers offer you discount pricing, which is significantly below retail. You receive substantial savings (15% - 40%) on additional eyewear pair purchases, contact lenses, lens treatments, specialized lenses and various sundry items.

Copayment(s): Copayment amounts are applicable to Blue View Vision Participating Provider services.

BENEFITS WILL BE PROVIDED ONLY FOR THE COVERED SERVICES SPECIFIED IN THIS SUMMARY OF BENEFITS. NO BENEFITS WILL BE PROVIDED FOR ANY OTHER SERVICES.

Blue View Vision Summary Plan Description	Blue View Vision Participating Providers (Your Copayment)	Non-Blue View Providers (Plan's Reimbursement)
Standard Prescription Lenses		
Single Vision Lenses	$25 Copayment	Up to $25
Bifocal Lenses (pair)	$25 Copayment	Up to $40
Standard Progressive Lenses (pair)	$25 Copayment plus an additional $65 Copayment	Up to $40
Trifocal Lenses (pair)	$25 Copayment	Up to $55
Availability: Once every 24 months[2]		
Frames	No Copayment. Maximum plan benefit of $100	Up to $45
Availability: Once every 24 months[2]		
Contact Lenses[3,4]		
Elective	No Copayment. Maximum plan benefit of $80	Up to $80
Non-elective	No Copayment. Maximum plan benefit of $250	Up to $210
Availability: Once every 24 months[2]		

1 Non-Network Reimbursement represents Plan's allowance toward eligible benefits and may not cover all charges.

2 Benefits are available from the last date of service

3 See the Policy for definitions of Elective and Non-elective Contact Lenses.

4. Contact lenses are in lieu of eyeglass lenses. If you choose elective contact lenses in a benefit period, we will not pay benefits for eyeglasses (lenses and frame) during that same benefit period.

WHAT IS NOT COVERED

No payment will be made under this Plan for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

COMPLICATIONS OF NON-COVERED SERVICES
Complications arising from non-Covered Services and supplies. Examples of non-Covered Services include but are not limited to, Cosmetic Surgery, operations and procedures which are determined to be Experimental/Investigational.

COSMETIC OPTIONS
Blended lenses/no line, oversize lenses, progressive multifocal lenses, photochromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, and UV-protected lenses, and other lens options.

CRIME OR NUCLEAR ENERGY
Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

EXCESS AMOUNTS
Any amounts in excess of the Covered Vision Expense.

EXPERIMENTAL OR INVESTIGATIONAL
Services or supplies which are Experimental/Investigational or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Anthem.

EYE SURGERY
Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

GOVERNMENTAL SERVICE
Any services actually given to you by a local, state, or federal government agency, except when payment under this Plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

HOSPITAL CARE
Inpatient or outpatient hospital vision care.

LOST OR BROKEN LENSES OR FRAMES
Any lost or broken lenses or frames, unless you have reached a new Benefit Period.

NON-PRESCRIPTION LENSES
Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

NOT SPECIFICALLY LISTED
Services not specifically listed in this Plan as Covered Services.

ORTHOPTICS
Orthoptics or vision training and any associated supplemental testing.

OVER THE COUNTER PRODUCTS
Items available without a prescription.

PRIVATE CONTRACTS
Services or supplies provided pursuant to a private contract between the Policyholder and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

SAFETY GLASSES
Safety glasses and accompanying frames.

SERVICES FOR SOMEONE OTHER THAN THE POLICYHOLDER
Any person other than the Policyholder, including but not limited to the Policyholder's dependent's such as spouse, domestic partner, legal ward, natural child, adopted child or child placed for adoption (except following birth, adoption or placement for adoption for the first thirty-one (31) days of coverage.

SERVICES FROM RELATIVES
Professional services or supplies received from a person who lives in your home or who is related to you by blood, marriage or adoption.

SUNGLASSES
Sunglasses and accompanying frames.

UNINSURED
Services received before your Effective Date or after your coverage ends.

VISION EXAMS OR TESTS
Vision examinations or vision tests.

VOLUNTARY PAYMENT
Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage.

WORK-RELATED
Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation employer's liability law or occupational law even if you do not claim those benefits, except for corporate officers who may opt out of Workers' Compensation coverage.

Anthem Blue Cross and Blue Shield & HMO Colorado
Health Benefit Plan Description Form Disclosure Amendment

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

Pursuant to Colorado law (C.R.S. §10-16-107(7)(a), services or supplies for the treatment of Intractable Pain and/or Chronic Pain are not covered.

This coverage is renewable at your option, except for the following reasons:

1. **Non-payment of the required premium;**
2. **Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
3. **The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations;**
4. **The carrier elects to discontinue offering and non-renew all of its individual plans delivered or issued for delivery in Colorado.**

Cancer Screenings

At Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado, Inc., we believe cancer screenings provide important preventive care that supports our mission: to improve the lives of the people we serve and the health of our communities. We cover cancer screenings as described below.

Pap Tests

All plans provide coverage for an annual Pap test and the related office visit. Payment for the Pap test is based on the plan's laboratory services provisions, and payment for the related office visit is based on the plan's preventive care provisions.

Mammogram Screenings

All plans except our HMO and PPO Basic Health Plans provide mammogram screening coverage for women in accordance with the "A" and "B" recommendations of the U.S. Preventive Services Task Force. Frequency guidelines can be found in your certificate. Payment for the mammogram screening benefit is based on the plan's provisions for X-ray services.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide prostate cancer screening coverage for men 40 years of age and older. Frequency guidelines can be found in your certificate. Payment for the prostate cancer screening benefit is based on the plan's provisions for X-ray services

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for colorectal cancer screenings, such as colonoscopies, sigmoidoscopies and fecal occult blood tests. Depending on the type of colorectal cancer screening received, payment for the benefit is based on the plan's provisions for laboratory services, preventive care office visit services, or other medical or surgical services. Our plans do not provide coverage for preventive colorectal cancer screenings involving invasive surgical procedures and DNA analysis.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Health Benefit Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Health Benefit Plan Description Form.