Anthem

CONNECTICUT

TONIK $3,000 Deductible

TONIK is a preferred provider organization (PPO) plan.

COST SHARE PROVISIONS	In-Network *Member pays:*	Out-of-Network *Member pays*:*
Calendar Year Deductible	$3,000	
Coinsurance	N/A	50% after deductible
Cost Share Maximum	$3,000 per calendar year	$10,000 per calendar year
Lifetime Maximum	Unlimited	

MEDICAL CARE	In-Network: After Calendar Year Deductible *Member pays:*	Out-of-Network: After Calendar Year Deductible *Member pays*:*
Medical Office visits – *including vision and hearing exams and allergy visits* *Visits 1-4*** *Subsequent visits* ***Note: Deductible is waived for the combined total of the first 4 preventive, medical and/or mental health and substance abuse visits in a Calendar Year*	 $25 Copayment (deductible waived) $0	 50% 50%
Preventive	No cost to member	50%
Maternity care	Not Covered	Not Covered
Diagnostic Lab, X-ray and Testing	$0	50%
High-Cost Outpatient Diagnostic X-rays – *prior authorization required*	$0	50%
HOSPITAL CARE – *Prior authorization required*		
Semi-private room *(General/Medical/Surgical)*	$0	50%
Skilled nursing facility – *up to 100 days per calendar year*	$0	50%
Rehabilitative services – *up to 100 days per person per calendar year*	$0	50%
Outpatient surgery – *in a hospital or surgi-center*	$0	50%
EMERGENCY CARE		
Urgent care – *at participating centers only*	$50 (deductible waived)	Not Covered
Emergency care – *copayment waived if admitted*	$100 Copayment (deductible waived)	$100 Copayment (deductible waived)
Ambulance	$0	50%
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Services	$0	50%
Professional Services *Visits 1-4*** *Subsequent visits* ***Note: Deductible is waived for the combined total of the first 4 preventive, medical and/or mental health and substance abuse visits in a Calendar Year*	 $25 Copayment (deductible waived) $0	 50% 50%

OTHER HEALTH CARE	In-Network: After Calendar Year Deductible *Member pays:*	Out-of-Network: After Calendar Year Deductible *Member pays*:*
Outpatient rehabilitative services – *up to 35 visits combined maximum for PT, OT, ST and Chiro per calendar year*	$0	50%
Durable medical equipment / Prosthetic Devices *Unlimited maximum per calendar year*	$0	50%
Diabetic equipment, drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier	Not Applicable	50%
Infertility Services – *prior authorization required*	$0	50%
Home Health Care – *up to 80 visits per member per calendar year*	$0	$50 Deductible & 20% Coinsurance
PRESCRIPTION DRUGS	**In-Network:** *Member pays:*	**Out-of-Network:** *Member pays:*
Purchased at a participating retail pharmacy – *30 day supply* *Tier 1 – Generic prescription drugs* *Tier 2 – Listed brand prescription drugs* *Tier 3 – Non listed brand prescription drugs*	 $10 Copayment $25 Copayment $40 Copayment	20%
Purchased by mail order – *90 day supply* *Tier 1 – Generic prescription drugs* *Tier 2 – Listed brand prescription drugs* *Tier 3 – Non listed brand prescription drugs*	 $20 Copayment $50 Copayment $80 Copayment	20%

DENTAL SERVICES - *$500 calendar year maximum*	After $50 calendar year deductible *Member pays*:*	
Diagnostic & Preventive Services – *2 exams and cleanings per calendar year*	$0 (Deductible waived)	The difference between the total charge and what the plan pays
Diagnostic & Minor Restorative Services	20%	

PREVENTIVE CARE SCHEDULES	
Well Child Care (including immunizations)	***Adult Exams***
◆ 6 exams, birth to age 1	◆ 1 exam every 5 years, ages 22 - 29
◆ 6 exams, ages 1 - 5	◆ 1 exam every 3 years, ages 30 - 39
◆ 1 exam every 2 years, ages 6 - 10	◆ 1 exam every 2 years, ages 40 - 49
◆ 1 exam every year, ages 11 - 21	◆ 1 exam every year, ages 50+
Mammography	***Vision Exams:*** 1 exam per calendar year
◆ 1 baseline screening, ages 35-39	***Hearing Exams:*** 1 exam per calendar year
◆ 1 screening per year, ages 40+	***OB/GYN Exams:*** 1 exam per calendar year
◆ Additional exams when medically necessary	

Notes To Benefit Descriptions

- Specified preventive services are only covered as part of the PCP visit when rendered at the same time as the exam. The Preventive Care Schedules above must be followed in order for the exam and associated services to be considered preventive.
- In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.
- Home Health Care services are covered when in lieu of hospitalization. Includes infusion (IV) therapy.
- Members must utilize participating Blue Quality Centers for Transplant hospitals to receive benefits for Human Organ & Tissue Transplant services. This network of the finest medical transplant programs in the nation is available to members who are candidates for an organ or bone

marrow transplant. A nurse consultant trained in case management is dedicated to managing members who require organ and/or tissue transplants.

* Members are responsible for the balance of charges billed by out-of-network providers after payment for covered services has been made by Anthem Blue Cross and Blue Shield according to the Comprehensive Schedule of Professional Services.

Please refer to the *SpecialOffers@Anthem* brochure in your enrollment kit for information on the discounts we offer on health-related products and services.

This does not constitute your health plan or insurance policy. It is only a general description of the plan. The following are examples of services NOT covered by your TONIK Plan. Please refer to your Subscriber Agreement/Certificate of Coverage/Summary Booklet for more details: Cosmetic surgeries and services; custodial care; genetic testing; hearing aids; refractive eye surgery; services and supplies related to, as well as the performance of, sex change operations; surgical and non-surgical services related to TMJ syndrome; travel expenses; vision therapy; services rendered prior to your contract effective date or rendered after your contract termination date; and workers' compensation.

A product of Anthem Blue Cross and Blue Shield serving residents and businesses in the State of Connecticut.