TONIK[SM] *$3,000 Plan effective 9-23-2010*

Anthem

Summary of Benefits

*This is only a brief summary of your coverage. Benefits apply when care is **medically necessary.** Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. However, if you receive services from an out-of-network provider, it is your responsibility to pay the difference between the MAB and the provider's charge.*

Service Received	Your Share of the Cost	
	Network Benefits	**Out-of-Network Benefits**∴
Preventive Care		
• Routine ancillary services *(e.g.; prostate screening, screening mammography, pap smears, colorectal cancer screening, cholesterol screening, and preventive immunizations and vaccines)*	Covered in full	Covered to MAB
Office Visits		
• Routine vision exam *(one exam per member per calendar year)*	$30 per visit for the first four (4) Office Visits per member per calendar year⬩	
• Routine hearing exam *(one exam per member per calendar year)*		
• Medical exams		
Other Outpatient Care	Subject to:	Subject to:
• Physical therapy, occupational therapy, and speech therapy *(up to a combined 30 visits per member per calendar year)*ϑ		
• CT scan and MRI, outpatient facility fees	$3,000 deductible per member per calendar yearσ	$3,000 deductible per member per calendar yearσ
• Lab, x-ray, and ultrasounds		
• Surgery in hospital outpatient department or ambulatory surgery center		and
Inpatient Care (as a bed patient in an acute care hospital)		50% coinsurance up to $7,000 per member per calendar yearσ
• Semi-private room and board		
• Physician in-hospital care, surgery, anesthesia, lab, x-ray, CT scan, MRI, medical supplies, medication and physical, occupational, and speech therapy		
Note: Maternity care (prenatal, admission, delivery, post-partum) is covered only if you have purchased a maternity rider.		
Skilled Nursing Facility *(up to 100 inpatient days per member per calendar year)*ϑ		*Some out-of-network benefits are subject to pre-certification requirements. Refer to your Subscriber Certificate for details. Call 1-800-531-4450 to pre-certify.*
Physical Rehabilitation Facility *(up to 100 inpatient days per member per calendar year)*ϑ		
Home Health Care *(up to 60 visits per member per calendar year)*ϑ		
Hospice *(unlimited)*ϑ		
Infusion Therapy		
Durable Medical Equipment (DME)		
Ambulance *(medically necessary emergency transport only)*		
Emergency Room (ER Visit)		
■ ER physician fee, CT scan, MRI, medical supplies, etc.		
■ ER charge (co-payment waived if admitted)	$100 per visit	

ϑ Any combination of benefits from either column count toward this maximum.

∴ Services are covered up to the maximum allowable benefit (MAB). Out of network providers may bill you for amounts that exceed the MAB.

σ Deductible amounts are shared between both columns.

⬩ For subsequent Office Visits, you pay the applicable Network deductible or Out-of-Network deductible and coinsurance.

9-28-10

Mental Health & Substance Abuse

For these services, ALL care must be authorized in advance by Behavioral Health Network (BHN) at 1-888-364-8665.
You will pay less if you utilize a network provider.

	Network Benefits	Out-of-Network Benefits∴
Outpatient services: - Visit/consultation **Inpatient services *(substance abuse services are limited to detoxification only)*:** - Semi-private room & board - MH/SA physician visit	Subject to deductible$^{\sigma}$	Subject to deductible and coinsurance$^{\sigma}$

Note: Inpatient and outpatient mental health and substance abuse benefits (combined) are limited to 20 visits per member per year. Any combination of network and out-of-network benefits counts toward this maximum.

Prescription Drugs

- Includes maintenance drugs at a retail or mail order pharmacy
  - Only certain drugs are considered "maintenance" and are available for a supply greater than 30 days.
  - You pay the generic co-payment for diabetic supplies.
- Important notes:
  - **Coverage is for generic drugs only.** If your doctor prescribes, or you choose to receive a brand drug, or if a generic drug is not available, your Anthem ID card will enable you to purchase brand name drugs at Anthem's negotiated cost, which is most often less than the retail cost.

	Network Benefits	Out-of-network Benefits∴
Prescription Drugs *(generic only)*	$10 co-payment *(co-payment applies to each fill, up to a 30-day supply)*	Not Covered
Mail Order *(generic prescription drugs only)*	$20 co-payment *(co-payment applies to each fill, up to a 90-day supply)*	

Dental Services

If you need further information, call Dental Customer Service at 1-800-440-3619.

Diagnostic & Preventive dental services
(limited to 2 exams and cleanings per member per year)
Diagnostic & Minor Restorative dental services

Plan pays benefit schedule amount after $50 deductible

Lifetime Maximums

Unlimited

This is only a brief summary of your coverage. Please review your Subscriber Certificate for complete details on exclusions and limitations.

This summary of benefits is not a contract. It is a general description of the benefits of this plan. Members age nineteen (19) and older may be subject to pre-existing condition limitations. Complete information about all benefits, limitations and exclusions is in the Subscriber Certificate, which will be mailed to you after you enroll. If you need further information, call Customer Service at 1-800-477-4864.

Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

- Injuries which are the responsibility of other parties
- Services for which another insurance carrier or Medicare is primary
- Services related to illegal conduct

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σ Deductible amounts are shared between both columns.

⬥ For subsequent Office Visits, you pay the applicable Network deductible or Out-of-Network deductible and coinsurance.