TONIK℠ *$3,000 Plan*

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 physical exam for babies, children and adults including family planning visits • Routine vision exam *(one exam per member per calendar year)* • Routine hearing exam *(one exam per member per calendar year)* • Medical exams	$30 per visit for the first four (4) Office Visits per member per calendar year◆	
Other Outpatient Care • Physical therapy, occupational therapy, and speech therapy *(up to a combined maximum of $3,000 per member per calendar year)* ϑ • CT scan and MRI, outpatient facility fees • Lab, x-ray, and ultrasounds • Surgery in hospital outpatient department or ambulatory surgery center	Subject to: $3,000 deductible per member per calendar yearσ	Subject to: $3,000 deductible per member per calendar yearσ and 50% coinsurance up to $7,000 per member per calendar yearσ ctible
Inpatient Care (as a bed patient in an acute care hospital) • 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 **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** *(up to $250,000 per member lifetime)*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.*
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	

ϑAny 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.

σDeductible amounts are shared between both columns.

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

NH-Tonik-First Release T56

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

Note: Inpatient and outpatient mental health and substance abuse benefits (combined) are limited to $3,000 per member per year and $10,000 per member per lifetime. 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 up to $500 per year

Lifetime Maximums

Total program maximum is $5,000,000 (*includes both network and out of network benefits*)

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. You 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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$^{\sigma}$Deductible amounts are shared between both columns.
◆For subsequent Office Visits, you pay the applicable Network deductible or Out-of-Network deductible and coinsurance.