Anthem
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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
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

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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.

DN18 01-01-10
06-00496 (1/10)

	IN-NETWORK	OUT-OF-NETWORK
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$5,000,000 combined in-network and out-of-network. Bariatric surgery has a lifetime maximum benefit by the carrier of $7,500 per member for services received from a Center of Excellence facility or a lifetime maximum benefit by the carrier of $1,500 per member for services received from a facility that has not been designated as a Center of Excellence; total lifetime maximum benefit by the carrier shall not exceed $7,500 per member in-network and out-of-network combined. Programs to stop tobacco use have a lifetime reimbursement maximum of $50 per member in-network and out-of-network combined.	$5,000,000 combined in-network and out-of-network. Bariatric surgery has a lifetime maximum benefit by the carrier of $1,500 per member for services received from a facility that has not been designated as a Center of Excellence; total lifetime maximum benefit by the carrier shall not exceed $7,500 per member in-network and out-of-network combined. Programs to stop tobacco use have a lifetime reimbursement maximum of $50 per member in-network and out-of-network combined.
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
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.

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	IN-NETWORK	OUT-OF-NETWORK
MEDICAL OFFICE VISITS (continued) 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.

	IN-NETWORK	OUT-OF-NETWORK
9. PREVENTIVE CARE		
a) Children's services	\$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. \$20 copayment per office visit, not subject to deductible (copayment does not apply to out-of-pocket annual maximum) for all other covered preventive care services.	\$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	\$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. \$20 copayment per office visit, not subject to deductible (copayment does not apply to out-of-pocket annual maximum) for all other covered preventive care services.	\$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
	Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.	

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	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 for participating providers, not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum); or $100 copayment per visit for non-participating providers plus you pay 40% coinsurance not subject to deductible (amounts paid do not apply to deductible or out-of-pocket annual maximum).
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).

	IN-NETWORK	OUT-OF-NETWORK
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	You pay all charges except for $175 per day (amounts paid do not apply to out-of-pocket annual maximum). Benefits are limited to a maximum Anthem benefit of $5,250 per calendar year with a maximum of 30 days per calendar year combined in-network and out-of-network.	You pay all charges except for $175 per pay (amounts paid do not apply to out-of-pocket annual maximum). Benefits are limited to a maximum Anthem benefit of $5,250 per calendar year with a maximum of 30 days per calendar year combined in-network and out-of-network.
b) Outpatient care	You pay all charges except for $25 per visit (amounts paid do not apply to out-of-pocket annual maximum). Benefits are limited to 20 visits per calendar year combined in-network and out-of-network.	You pay all charges except for $25 per visit (amounts paid do not apply to out-of-pocket annual maximum). Benefits are limited to 20 visits per calendar year combined in-network and out-of-network.
20. ALCOHOL & SUBSTANCE ABUSE	Not covered	Not covered
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 for participating providers. For non-participating providers after deductible you pay all charges except $25 per visit (amounts paid do not apply to the out-of-pocket annual maximum). 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.

	IN-NETWORK	OUT-OF-NETWORK
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.
26. HOSPICE CARE	No copayment; 100% covered after deductible. Benefits for routine home care are limited to a maximum Anthem benefit of $100 per day in-network and out-of-network combined.	40% coinsurance after deductible. Benefits for routine home care are limited to a maximum Anthem benefit of $100 per day in-network and out-of-network combined.
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.

	IN-NETWORK	OUT-OF-NETWORK
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Program to Stop Tobacco Use: Reimbursement of up to $50 per lifetime in-network and out-of-network combined. 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: Reimbursement of up to $50 per lifetime in-network and out-of-network combined. 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, 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"?	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 benefit allowance. You will be responsible for any balance of a non-participating provider's bill which is above the maximum benefit allowance 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.

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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.

	Plan Pays

Covered Services		(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

Questions? Visit our website www.MediCoverage.com/TONIK or call customer service at (800) 930-7956 opt. 2

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.

Questions? Visit our website www.MediCoverage.com/TONIK or call customer service at (800) 930-7956 opt. 2

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.**

Questions? Visit our website www.MediCoverage.com/TONIK or call customer service at (800) 930-7956 opt. 2

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.