Anthem BlueCross

Tonik® health care plan for California

It's all about you.

You're young. You're healthy. But life is unpredictable. All it takes is one slip, one illness and the financial pain can outweigh the physical. Being covered for health care is vital. It can make all the difference when it comes to the health of your body and your budget.

With Tonik, it's all about you having a health care plan that fits your finances, and your way of life.

CABR10001XTK Rev. 5/12

Tonik. The big picture.

Immediate coverage (no deductible) for the benefits you're most likely to use:

Plan benefits for calendar year in network	Thrill Seeker aka 5000
Office Visits	**$20 per visit, 4 visits/year** (additional visits covered in full after you meet your annual deductible)
Prescription Drugs (generic only)	**$15 for a 30-day supply from a network retail pharmacy or $30 for up to a 60-day supply through mail order**
Nationally mandated preventive coverage	**0% Coinsurance, not subject to deductible**

If you need these services, just pay your deductible and we'll pay the rest.

Professional Services (X-ray, lab, anesthesia, surgeon, etc.)	**$0 after you meet your annual deductible**
Overnight Hospital Stays (surgery, lab work, doctor charges, anesthesia and any other covered hospital charges)	**$0 after you meet your annual deductible**
If You Don't Stay Overnight (fracture repairs, shoulder or knee arthroscopies, etc.)	**$0 after you meet your annual deductible**
Emergency Room Care (includes all covered servicesreceived in ER)	**$0 after you meet your annual deductible**
Maternity Services	**$0 after you meet your annual deductible**
Deductible (how much you'll pay each year before we start paying for services, like hospitalization)	**$5,000**
Out-of-pocket Maximum* (the amount you pay after meeting your deductible)	**$0**

*Does not include office visit, prescription, dental or vision copays.

Even your teeth and eyes can get some benefits:

You'll pay $0 for cleanings, exams and X-rays. After you pay your $25 deductible, you'll pay 20% for minor restorative procedures like fillings. We'll pay up to $500/year for your dental benefits. And Tonik Optional Enhanced Dental offers additional benefits.

You'll pay only $25 for basic eyeglass lenses and receive up to $100 toward frames or $80 toward contact lenses every 24 months. In addition, we'll pay $50 for an eye exam or to help out on the cost of glasses or contact lenses every 12 months. How's that for eye-catching?

After 9/23/12, to view a Summary of Benefits and Coverage, please visit www.healthcare.gov

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Medical copays for office visits, prescriptions, dental or vision don't apply toward the deductible or out-of-pocket maximum. This is only an overview of the Tonik plan benefits. For a complete listing of all the benefits, limitations and exclusions, or call 800-317-9818 to request a policy. Rates are subject to change.

Getting hurt without coverage. It's pain you'll feel all the way to your wallet.

Example of what you could pay:

	No Health coverage	With Tonik coverage
Burst appendix (ouch)	$48,151	$5,000

Want more?

As you can see on the chart, Tonik also includes some basic dental benefits. And if you sign up for Tonik Optional Enhanced Dental when you apply for Tonik, you can also get coverage for things like oral surgery, scaling, root canals and crowns.

But enough about you. What about your family? What'll happen to them if something happens to you? Check out the term life insurance plans offered by Anthem Blue Cross Life and Health Insurance Company. You can get life insurance coverage from $15,000 to $100,000, and you can sign up when you apply for Tonik.

The bottom line.

You know you need insurance. I'm here to make it easy for you to find the plan that best fits your lifestyle. And you don't have to pay for my services. Tonik is fast and online – so apply now by calling me or going to my website below.

Presented by:

Call your Anthem Blue Cross agent today!

Anthem BlueCross

Notes:

– Discounted rates apply for network covered services.
– For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.
– Copays/coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the policy.

California Coverage Details

Things you need to know before you buy...

Anthem BlueCross

ClearProtection℠, CoreGuard℠ Plus, Lumenos® HSA Plus, Premier Plus, SmartSense®Plus, Tonik®, PPO Share, HMO Saver, Individual HMO, Select HMO

Before choosing a health care plan, please review the following information, along with the other materials enclosed.

To Enroll, You And Your Dependents Must Be:

- Age 64¾ or younger
- A permanent legal resident of California
- A U.S. resident for at least the last 3 months
- The applicant's spouse or domestic partner, age 64¾ or younger
- The applicant's children (under 26 years of age), or the children (under 26 years of age) of the applicant's enrolling spouse or qualified domestic partner
- The applicant's child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and is chiefly dependent upon the applicant for support and maintenance

Medical Underwriting Requirement

We believe that the cost of our plans should be consistent with your expected health care needs and risk factors. That's why Anthem offers various levels of coverage. To determine individual medical risk factors, all applications are subject to medical underwriting. Depending on the results of the underwriting review, a number of things may happen:

- You may be offered coverage at the standard premium charge
- You may be offered the plan you selected at a higher rate
- You may not qualify for the plan listed in this brochure
- You may be offered an alternate plan

If you have a significant medical condition and do not qualify for the plan you've chosen or if you have discontinued group coverage, please contact your Anthem representative for information regarding other Individual coverage options.

Important Information for Applicants Under the Age of 19

As provided by California AB 2244 (2010), an applicant under the age of 19 may be assessed a 20% surcharge for the 12-month period following the effective date of enrollment. The surcharge would apply if the applicant has not had continuous coverage during the 90 day period prior to the date of application and is not a late enrollee. If applying for coverage outside of the birthday month or a special late enrollee period, a higher rate may apply.

Medical Loss Ratio

As required by law, we are advising you that Anthem Blue Cross' medical loss ratio for 2011 was 80.9 percent. The 2011 medical loss ratio for Anthem Blue Cross Life and Health Insurance Company was 79.9 percent. These ratios were calculated after provider discounts were applied and based on state and federal regulatory rules and regulations including the federal MLR regulations.

Waiting Periods

For applicants age nineteen (19) and older, there is a specific six-month waiting period for coverage of any condition, disease or ailment for which medical advice or treatment was recommended or received within six months preceding the effective date of coverage. If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the six-month waiting period. Anthem will credit the time you were enrolled on the previous plan. The pre-existing condition limitation does not apply to applicants under age nineteen.

Access To The MIB

In accordance with federal and state privacy laws, Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company or its reinsurers may, obtain and disclose personal health information to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

You may have an MIB record if you have applied for individual insurance (life, health, disability income, long-term care or critical illness insurance) in the last seven years with a MIB Member company. You may obtain a free copy of your MIB file annually, if one exists, upon request, and subject to proper identification, by contacting MIB at 866-692-6901 (TTY 866-346-3642). If after receipt and review of your MIB file, you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act and applicable state law.

The address of MIB's Information Office is:
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734.

Information for consumers about MIB may be obtained on its website at www.mib.com.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review/Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services, including therapy for Pervasive Developmental Disorders
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What Individual Health Care Plans Do Not Cover

The following overview will help you understand what your health care plan does not include before you enroll. For a comprehensive list of the plans' exclusions and limitations, you can request a copy of the Policy/ Evidence of Coverage (EOC).

Medical Exclusions And Limitations

Exclusions

- Conditions covered by workers' compensation or similar law
- Experimental or investigative services
- Services provided by a local, state or federal government, unless you have to pay for them
- Durable Medical Equipment, except as specifically stated in the policy
- Services or supplies not specifically listed as covered under the Policy/EOC
- Services received before your effective date or after coverage ends
- Services you wouldn't have to pay for without insurance
- Services from relatives
- Any services received by Medicare benefits without payment of additional premium
- Services or supplies that are not medically necessary
- Routine physical exams (e.g., physical exams for insurance, employment, licenses or school are not covered), except for preventive care services specifically stated in the Policy/EOC.
- Sex changes
- Cosmetic surgery
- Services primarily for weight reduction except medically necessary treatment of morbid obesity
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Policy/EOC
- Orthodontic services, braces, and other orthodontic appliances
- Hearing aids
- Infertility services
- Private duty nursing
- Eyeglasses or contact lenses, except as specifically stated in the Policy/EOC
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Policy/EOC
- Specialty drugs from a pharmacy other than our specialty drug provider
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Policy/EOC
- Services or supplies related to a pre-existing condition, for applicants age nineteen and older
- Outdoor treatment programs
- Telephone, facsimile machine and electronic mail consultations
- Educational services except as specifically provided or arranged by Anthem
- Nutritional counseling, food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU)
- Personal comfort items
- Custodial care
- Outpatient speech therapy, except as specifically stated in the Policy/EOC
- Certain genetic testing
- Services or supplies provided to any person not covered under the Agreement in connection with a surrogate pregnancy

Medical Exclusions and Limitations (continued)

Limitations

Acupuncture and Acupressure:

- ClearProtection Plus, CoreGuard Plus, Premier Plus, SmartSense Plus and Tonik: Not Covered
- Lumenos HSA Plus or PPO Share: 24 visits per calendar year. All visit limits for Acupuncture and Acupressure are combined and apply to the visit limit.

Physical Therapy, Occupational Therapy and Chiropractic Services:

- CoreGuard Plus, Lumenos HSA Plus, PPO Share, Premier Plus or Tonik: 24 visits per calendar year. All visit limits for Physical Therapy, Occupational Therapy and Chiropractic Services are combined and apply to the visit limit.

Physical Therapy and Occupational Therapy Services:

- ClearProtection: 24 visits per calendar year. All visit limits for Physical Therapy and Occupational Therapy are combined and apply to the visit limit. Chiropractic services are not covered.

Physical Therapy, Occupational Therapy and Speech Therapy Services:

- SmartSense Plus: 24 visits per calendar year. All visit limits for Physical Therapy, Occupational Therapy and Speech Therapy are combined and apply to the visit limit.

Chiropractic Services

- SmartSense Plus: 20 visits per calendar year

Mental or Nervous Disorders and Substance Abuse:
(This does not include the treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child)

- Inpatient
  - ClearProtection: Not covered
  - CoreGuard Plus, Lumenos HSA Plus, Premier Plus, SmartSense Plus, Tonik or PPO Share: 30 days per calendar year
- Outpatient
  - ClearProtection: Not covered
  - Lumenos HSA Plus, SmartSense Plus, Tonik or PPO Share: 1 visit per day, 20 visits per calendar year
  - CoreGuard Plus or Premier Plus: 1 visit per day, 48 visits per calendar year.

In addition the **Individual HMO, HMO Saver and Select HMO** plans do not cover:

- Care not authorized by your Primary Medical Group or Independent Practice Association
- Amounts in excess of customary and reasonable charges for care rendered by a non-participating provider without a referral from your PMG or IPA
- Chiropractic services
- Immunizations for foreign travel
- Treatment for chronic alcoholism or other substance abuse except as specifically stated in the Evidence of Coverage
- Inpatient mental care, including acute alcoholism and drug addiction benefits, except detoxification
- Treatment of mental and nervous disorders, except as specifically stated in the Evidence of Coverage

Limitations

- Rehabilitative care specifically stated in the Evidence of Coverage
- Reconstructive surgery, purchase or replacement of artificial limbs or prosthesis except as specifically stated in the Evidence of Coverage
- Medical, surgical and/or psychological treatment of a sexual dysfunction, except when a sexual dysfunction is a result of a physical abnormality, defect or disease
- Medical, surgical services, supplies or treatment to the joint of the jaw (temporomandibular joint), upper jaw (maxilla) or lower jaw (mandible), unless related to a tumor or accident occurring while covered
- Routine physical examinations or tests that do not directly treat an acute illness, injury or condition unless authorized by your Primary Care Physician, except in no event will any physical examination or test required by employment or government authority, or at the request of a third party, such as a school, camp or sports-affiliated organization, be covered unless medically necessary

Dental Blue® PPO Limitations And Exclusions

Limitations

This is a partial list of plan limitations. Please see the Individual Dental Plan Contract for a complete list.

- Oral Evaluations: Limited to two per calendar year
- Routine Cleaning or Periodontal Cleaning: Limited to two treatments per calendar year
- Fluoride: Fluoride treatment limited to two per calendar year for children up to age 19
- X-rays: Limited to one set of full-mouth X-rays or its equivalent in a five-year period
- Periapical X-rays: Limited to four films per year
- Bitewing X-rays: Limited to one set of up to four films twice per calendar year
- Sealants: Limited to children under 16 years of age for permanent unrestored first and second molars
- Treatment is limited to one application per tooth per lifetime
- Space Maintainers: Limited to once per quadrant per lifetime for children up to age 16. Includes all adjustments within six months of placement
- Restorations: Limited to once per surface per tooth every 24 months
- Periodontal Scaling: Limited to once per quadrant every 24 months
- Periodontal Surgery: Limited to one time per quadrant in a 36-month period
- Root Canal Therapy: Limited to one treatment per tooth for initial treatment and one retreatment per tooth — for permanent teeth only
- Stainless Steel Crowns: Limited to baby teeth only. Once per tooth in any five years
- Crowns: Limited to once per tooth in any five years
- Removable, Partial and Complete Dentures: Limited to once in five years. Benefits are payable for either complete or immediate dentures, but not both
- General Anesthesia: Covered only when used in conjunction with covered oral surgical procedures

Exclusions

This is a partial listing of plan exclusions. Please see the Individual Dental Plan Contract for a complete list.

- Prescribed drugs, pre-medication or analgesia including charges for nitrous oxide or any similar local anesthetic when the charge is made separately
- Occlusal guards
- Bleaching of non-vital discolored teeth
- Crown buildups on the same tooth as an amalgam or composite restoration that was done within the same calendar year
- Procedures to alter, restore or maintain occlusion, change vertical dimension, and replace or stabilize tooth structure lost by attrition, abrasion, erosion or bruxism
- Harmful habit appliances
- Services related to diagnosis or treatment related to the temporomandibular joint (TMJ)
- Dental implants and all adjunctive services performed in conjunction with the placement or removal of implants including but not limited to surgery, cleanings, maintenance and prosthetics placed on implants
- Infection control procedures, if billed separately
- Precision attachments
- Prefabricated resin crown or stainless steel crown with resin window
- Pulpotomy on permanent teeth
- Replacement of a prosthodontic appliance (fixed or removable) more often than once in any five-year period, whether under this contract or under any prior dental coverage
- Root canal therapy on baby teeth
- Sealants on restored teeth (occlusal surface)
- Temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.)
- Biopsies
- Services or supplies not specifically listed in the covered services section of the Individual Dental Plan Contract

Dental SelectHMO Limitations And Exclusions

This is a partial listing of plan limitations and exclusions. Please see the Contract for a complete list.

- Experimental or investigative care or therapy
- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication, settlement or otherwise, under any workers' compensation or occupational disease law, even if you do not claim these benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, Anthem Blue Cross Life and Health Insurance Company will provide the plan benefits for such conditions subject to its right of recovery and reimbursement under California Labor Code Section 4903
- Any services for which you are entitled to receive Medicare benefits, whether or not Medicare benefits are actually paid
- Any services provided by a local, state, county or federal government agency, including any foreign government, except when payment under the plan is expressly required by federal or state law
- Services or supplies for which no charge is made, or for which no charge would be made if you had no insurance coverage, or services for which you are not legally obligated to pay
- Services received before your effective date or during an inpatient stay that began before your effective date
- Services rendered before coverage begins or after coverage ends
- Prescribed drugs, pre-medication or analgesia (including nitrous oxide)
- No benefits are provided for hospital or associated physician charges for any dental treatment that cannot be performed in the dentist's office because of your general health, mental, emotional, behavioral or physical limitations
- Unless an exception is specifically authorized by Anthem Blue Cross in writing, dental services must be received from your participating dentist or participating specialty dentist
- A dental treatment plan, which in the opinion of the participating dentist and/or Anthem Blue Cross is not dentally necessary for dental health or will not produce beneficial results
- Conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy
- Treatment of fractures or dislocations
- Any treatment to correct a dental condition that resulted from dental services performed by a non-participating dentist while coverage is in effect and any dental services started by a non-participating dentist will not be the responsibility of the participating dentist or Anthem Blue Cross for completion
- Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies not covered under the medical plan
- Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Plan will allow for observation or extraction and prosthetic replacement
- Services received after the benefit limit under this agreement is reached
- Orthodontic services must be received from a participating orthodontist. In the event of loss of coverage for any reason, and at the time of loss of coverage you are still receiving orthodontic treatment, you will be responsible for the remainder of the cost for that treatment
- Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances that were broken due to negligence
- Myofunctional therapy and related services
- Surgical procedures incidental to orthodontic treatment, including but not limited to extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate
- Changes in treatment necessitated by an accident of any kind
- Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance

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This document provides a brief summary of provisions and does not include the full extent of exclusions and limitations. If there is any difference between this document and the Policy, the Policy will prevail. We want you to understand what your coverage does not include before you enroll. The Policy/Evidence of Coverage booklets contain a comprehensive list of the plans' exclusion and limitations which you should read before you enroll. For a sample copy of the Policy/Evidence of Coverage booklet, ask your agent or contact Anthem Blue Cross.

This summary of benefits provided in the enclosed brochure complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to the summary of benefits in the brochure.

Selecting health coverage is an important decision.

To assist you, we are also providing you with the Brochure and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem Blue Cross agent to request them.

The Policy/Evidence of Coverage booklets are also available for you to examine before enrolling. Ask your agent or Anthem Blue Cross.