

Tonik.®

Get hooked up.



It's all about you.



You're young. You're healthy. But hey, life is unpredictable. All it takes is one slip, one fall, one biff, and the financial pain can outweigh the physical. Whether you're laid out on the snow, sand or grass, you're going to wish you were covered.

We offer straight-up affordable health insurance plans to cover your A-Z.

We can help protect you from just about anything—even yourself.



Tonik. The big picture.

Plan Benefits per Calendar Year (in-network)

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 (includes all covered professional services like routine physical exams, lab work and X-rays you receive in your doctor's office during the office visit) | \$20 per visit, 4 visits/year (additional visits covered in full after you meet your annual deductible) |
| Emergency Room Care (includes all covered services received in ER) | \$100 for each visit |
| Prescription Drugs (generic only) | \$10 for a 34-day supply from a network retail pharmacy or \$20 for up to a 90-day supply through mail order |
| Nationally Recommended Preventive Care | 0% coinsurance, not subject to deductible |

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

| | |
|---|---|
| Other Professional Services (X-rays, blood tests, anesthesia, etc., received separately from professional services covered under your office visit) | \$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 |

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 percent for minor restorative procedures like fillings. We'll pay up to \$500/year for your dental benefits. We'll pay \$50 toward a routine eye exam, glasses or contact lenses and you'll pay the rest.

| | |
|--|---------|
| 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 copayments.

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.

Tonik doesn't include maternity benefits. Copayments for office visits, ER visits and prescription drugs 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, check out our website at tonikhealth.com, 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 |

The bottom line.

You know you need health 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 get amped and apply now by calling me or going to my website below.

Presented by:

tonikhealth.com

Anthem 

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NVBR11001XTK (9/10)



WELCOME TO TONIKSM
We've got you covered.

Congratulations! By enrolling in your own health insurance, you've made a wise investment in your health and financial future. You can begin to use your plan on the Effective Date printed on your ID card.

Get Plugged In

The hardest part is behind you – but there are still a few very important things about your health coverage you should be aware of. Like knowing how to program your cell phone or setting up your stereo, you have to make sure you know how your plan works in order to get top performance. We want you to get the most out of your coverage, and this booklet will tell you how. So get comfortable and take a few minutes to review the information. It's important that you read it carefully and understand it. It is our contract with you and tells you what benefits you can get and what the terms, conditions, limitations and exclusions of your coverage are. When you're done, you will know:

- How to take advantage of benefits to keep you healthy
- What to do in an emergency
- How to get special care if you need it
- What's not covered

As you read, you'll see certain terms that are capitalized. You can find out the meaning of these words by looking in the back under Important Terms to Know.

Internet and Phone Resources

You can also find information easily and quickly on your plan by checking out our web site **tonikhealth.com**. If you don't understand something, or you have a question call us at (800) 317-9818. Sometimes we record phone calls to make sure that the people you talk to are friendly and helpful.

This Policy is not a Medicare Supplemental Policy. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide from Anthem.

James E. Oatman
VP and GM West Markets, Individual Business
Anthem Blue Cross and Blue Shield

Anthem Individual TONIK \$5,000
DN12, 061N

09-2010

DN12, 061N
Anthem Blue Cross and Blue Shield Individual
Tonik \$5,000

A PPO Plan

Issued By
Anthem Blue Cross and Blue Shield (Anthem)

This booklet is called a Policy. It will tell you how your health plan works, which health services are covered and which services are not covered. It will tell you what your benefits are, when and how you have (and don't have) a right to these benefits. Please read your Policy completely and carefully. If you have special health care needs, carefully read those sections that apply to you.

YOU HAVE THE RIGHT TO LOOK AT THIS POLICY PRIOR TO ENROLLMENT.

You can request a copy of the "Notice of Privacy Practices," which explains your privacy rights. You can get a copy by checking our web site at tonikhealth.com or by calling us at (800) 317-9818.

Your health benefit coverage is defined in the following documents:

- This Policy and any amendments or endorsements thereto
- Your individual enrollment application/change form
- Your identification card
- Your individual rate sheet

Anthem enters into this Policy with you based upon the answers submitted by you, (or, if the Policyholder is under the age of 18 years, by the Policyholder's parent or guardian) on the signed individual enrollment application. In consideration for the payment of the premiums stated in this Policy, we will provide the services and benefits listed in this Policy to you subject to all the terms, conditions, limitations and exclusions of this Policy.

In this Policy, "we," "us" and "our" mean Anthem Blue Cross and Blue Shield. "You," "your" and "Policyholder" means the eligible Policyholder whose individual enrollment application has been accepted by us.

If you are under the age of 18 years, your parent or legal guardian may not have your rights as the Policyholder, but your parent or legal guardian will be considered the responsible party, and therefore, will be held liable for all financial and/or contractual obligations of this Policy until you are 18 years of age.

Note: This Policy covers the named Policyholder only and does not provide benefits for dependents, such as a spouse, domestic partner, legal ward, natural child, adopted child, child placed for adoption and/or newborn child as described in the PART called WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE. However, if you have a dependent, he or she may apply for coverage as a policyholder under his or her own separate policy. A completed application must be received by Anthem if you are requesting coverage for a dependent. For dependents under the age of 18 years (including newborns, adopted children and children placed for adoption), a parent or guardian must complete the application on behalf of the dependent. **Please be aware that an application for coverage does not guarantee coverage; all applications are subject to medical underwriting.**

The benefits of this Policy are intended for use in the state of Nevada. Any benefits received for services performed outside the state of Nevada may be significantly lower and result in a greater out-of-pocket expense for you since they are considered Out-of-Network Providers.

The benefits of this Policy are provided only for services that are considered Medically Necessary. The fact that a Provider prescribes or orders the service does not, in itself, make it Medically Necessary or a Covered Service. Anthem, or anyone acting on our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner that is consistent with the terms of this Policy. In the event of any question as to the interpretation of any provision of this Policy, Anthem's determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, or, in the case of surgery, cosmetic. However, you may utilize all applicable complaint, grievance and appeal procedures available under this Policy.

This is not an annual Policy. The duration of your coverage depends on the method of payment you choose under the Section entitled DURATION OF YOUR POLICY, and is not affected by any provisions defining your Deductible or other cost sharing obligations. Your Policy expires at the end of each billing cycle but will automatically renew upon timely payment of your next premium, subject to Anthem's right to terminate, cancel, or non-renew as described in the Section entitled HOW YOUR COVERAGE ENDS. Also, premiums, benefits, terms and conditions may be modified at any time during the year as allowed by Nevada state law. Please read the Sections entitled DURATION OF YOUR POLICY, HOW YOUR COVERAGE ENDS and NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY, carefully and in their entirety to make sure you fully understand the duration of your coverage and the conditions under which we can terminate, cancel or decline to renew your Policy.

THE ENTIRE POLICY SETS FORTH, IN DETAIL, THE RIGHTS AND OBLIGATIONS OF BOTH YOU AND ANTHEM. IT IS, THEREFORE, IMPORTANT THAT YOU READ YOUR ENTIRE POLICY CAREFULLY.

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PART 1 HOW TO USE YOUR HEALTH PLAN

As a Policyholder, you have a wide range of medical benefits, so it's important that you know how your plan works in order to use them to your best advantage.

USING YOUR ID CARD

Your Anthem identification (ID) card not only identifies you, but it also lists important phone numbers. Carry your ID card with you at all times and present it whenever you receive medical care or services. You can find your Effective Date of coverage on your ID card. This is the date your health care benefits start with us. You are the only person who can get health care services under this Policy. If you let someone else use your ID card, your coverage could be terminated even back to its original Effective Date.

CHOOSING DOCTORS AND HOSPITALS

Please read the following information carefully because the type of Provider you choose will affect your payment responsibility.

PROVIDERS

Benefits are available In-Network

Anthem Preferred Provider Organization (PPO) Plan gives you access to care through a network of Hospitals, Physicians and other Providers.

Preferred Providers (PPO Providers) contract with us to provide services to you at pre-negotiated discounted rates (called the Contracted Amount), which helps provide maximum savings for you. PPO Providers have a Preferred Provider Agreement in effect with us and have agreed to accept the Contracted Amount as payment in full. In addition, PPO Providers will file your claims with us. You are responsible for determining if your Provider is a PPO Provider. For a directory of PPO Providers or more information, visit our website or call us toll free. **Note:** If you need to have services in a Hospital, whenever possible you should be sure to request that the Professional Providers (such as anesthesiologists, pathologists or radiologists) who provide treatment to you are PPO Providers. Even if a Hospital is a PPO Provider, some Providers at the Hospital may not be PPO Providers.

Benefits are still available Out-of-Network

Non-PPO Providers

You can still go to Out-of-Network Providers (called Participating or Non-Participating Providers) and receive benefits for Covered Services. However, your out-of-pocket expense may be higher than when you visit an In-Network Provider.

Participating Providers have entered into a Participating Provider Agreement with Anthem to bill Anthem directly for Covered Services. The Participating Provider Agreement differs from the network agreement that PPO Providers sign. Although Anthem has contracted with Participating Providers, they are non-PPO Providers. Participating Providers have agreed to accept our Contracted Amount as payment in full. Even though you will pay a greater share of the cost when you use Participating Providers, you will not be responsible for costs above our Contracted Amount.

Note: If you need to have services in a Hospital, whenever possible you should be sure to request that the Professional Providers (such as anesthesiologists, pathologists or radiologists) who provide treatment to you are Participating Providers. Even if a Hospital is a Participating Provider, some Providers at the Hospital may not be Participating Providers.

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

Questions? Visit our web site tonikhealth.com or call customer service **1-800-317-9818**

they like, but we will pay benefits 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 described in this Policy, except as provided below.

We will reimburse Covered Services received from a Non-Participating Provider on the basis of billed charges rather than Maximum Benefit Allowance in the following circumstances:

- **Emergency care (where rendered either within or outside the State of Nevada)**
- **Where in-patient Hospital care at a Non-Participating Provider is necessary due to the nature of the treatment. In this situation an Authorized Referral is required.**
- **Where in-patient Hospital care at a Non-Participating Provider is necessary due to Participating Provider Hospital capacity. In this situation an Authorized Referral is required.**

In all other situations the Maximum Benefit Allowance does apply.

For emergency care, once you are stabilized, ongoing care and treatment is not emergency care. Continuation of care from a Non-Participating Provider beyond what is needed to evaluate and/or stabilize you will be paid subject to our Maximum Benefit Allowance and the Out-of-Network cost sharing requirements.

Anthem makes no guarantee that a PPO Provider will be available for all services and supplies covered under your PPO coverage. For a limited number of supplies and services, Anthem does not have arrangements with PPO Providers. Under these circumstances, you will be responsible for paying any charges from the Non-Participating Provider that exceed the Maximum Benefit Allowance paid by Anthem to the Provider except as provided above. The counties in which Anthem does not have PPO Providers for such services and supplies can be obtained by calling our customer service department. **If Anthem does not have a PPO Provider for a Covered Service and Anthem does not inform you of an alternative for obtaining the service from a non-PPO or Non-Participating Provider, you may request an Authorized Referral and, if granted, seek service from a non-PPO or Non-Participating Provider. To obtain an Authorized Referral contact our customer service department at (800) 317-9818. You will pay no more than what you would have paid for such Covered Service if it had been received from a PPO Provider. However, in some circumstances Anthem may require you to travel a reasonable distance for care within our Provider network to receive services from a PPO or Participating Provider.** Under these circumstances, if you knowingly choose to obtain the service from a Non-Participating Provider rather than the PPO or Participating Provider, you will be responsible for paying any charges from the Non-Participating Provider that exceed the Maximum Benefit Allowance paid by Anthem to the Provider. Anthem will not deny or restrict PPO Covered Services solely because you obtain treatment from a non-PPO Provider or Non-Participating Provider; however, you may have a higher financial responsibility.

Nothing contained in this Policy restricts or interferes with your right to select the Hospital, attending Physician or other Provider of your choice. Payments of benefits under this Policy do not regulate the amounts charged by Providers of medical care.

MAKING AN APPOINTMENT WITH THE DOCTOR

Call the doctor's office for an appointment and tell them you are insured with us. Have your identification (ID) card with you when you call because you may be asked for the ID number on your card. If you're going to be late or you can't go to your appointment, be sure to call your doctor's office as soon as possible. This will help your doctor reduce the time everyone waits in the waiting room.

GETTING A SECOND MEDICAL OPINION

If you have a question about your condition, or about a plan of treatment that your Physician has recommended, you may receive a second medical opinion from another Physician. This second opinion visit will be covered according to the benefits, limitations and exclusions of this Policy. If you wish to receive a second medical opinion, remember your financial responsibility will be less when you choose a PPO Physician. You should ask your Physician to refer you to a PPO Physician to receive a second opinion.

How To SUBMIT A CLAIM

PPO and Participating Providers will submit your claims to us. However, if you go to a Non-Participating Provider either you or the Provider of the service must claim benefits by sending Anthem properly completed claim forms itemizing the services or supplies received, and the charges. Claim forms that you or the Non-Participating Provider submits must be received by Anthem within three hundred sixty-five (365) days from the date the services or supplies are received. If we fail to provide you a claim form within fifteen (15) days of your request, you will be deemed to have complied with the requirements of this Policy for submitting a claim as long as you submit a written request including a copy of the bill from the Provider within the time frame above. Claims will be processed in accordance with the time frame as required by state law for the prompt payment of claims, to the extent such laws are applicable.

Claim forms must be used; canceled checks or receipts are not acceptable. Claim forms are available on our web site at **tonikhealth.com**. You can also request claim forms by telephone at (800) 317-9818, or by writing to us. Use the following address to request claim forms or to send your completed claim forms:

Anthem Blue Cross and Blue Shield
P.O. Box 5747
Denver, CO 80217-5747

Please remember that we will not pay for services or supplies for the treatment of a Pre-existing Condition during a period of twelve (12) months following your Effective Date except for those services which are required to be covered not subject to the Pre-existing Condition waiting period as required by state law.

For information about how your plan works, including your Deductible, Copayments, Coinsurance, out-of-pocket maximum and any benefit maximums covered under this Policy, please see the PARTS called HOW YOUR PLAN WORKS WHEN YOU NEED CARE and BENEFITS SUMMARY.

Questions? Visit our web site **tonikhealth.com** or call customer service **1-800-317-9818**

PART 2 WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE

WHO IS ELIGIBLE FOR COVERAGE

A Resident of the state of Nevada who has properly applied for coverage and who is insurable according to our applicable underwriting requirements.

Only the named Policyholder is eligible for benefits under this Policy. Other persons, including, but not limited to, the Policyholder's dependents, such as a spouse, domestic partner, legal ward, natural child, adopted child, child placed for adoption and/or newborn child, **are not** eligible for coverage under this Policy. However, those persons may apply for coverage under a separate policy. **Please be aware that an application for coverage does not guarantee coverage; all applications are subject to medical underwriting for members age 19 and above.**

RIGHT OF REFUND

You have the right to read this Policy. If you are not satisfied for any reason, you may notify Anthem in writing within ten- (10) days of your Effective Date to terminate your coverage. We will refund to you all premiums paid for that ten- (10) day period unless benefits have been paid, in which case we will use the premium payments to offset benefit payments. We reserve the right to recover any benefits payments made by us for claims during that ten- (10) day period.

YOUR EFFECTIVE DATE

The Effective Date of your coverage is printed on your Anthem identification ID card which is issued together with this Policy and is a part of this Policy.

MONTHLY PREMIUMS

The premiums printed on your individual rate sheet, which is included within and made a part of this Policy, are payable in advance and due the first of the month.

There are several payment options available:

- Monthly premium payments are an option if you pay with an automatic checking account deduction (we deduct premium from your checking account every month) or credit card (we charge your credit/debit card every month).
- Bi-monthly or quarterly paper billing (you will receive a bill in the mail every 2 or 3 months).
- Premium payments can be made over the phone from your checking account if you use "check by phone" or you can use your credit card

If you do not select a payment option, you will receive a bill in the mail every 2 months.

You will be responsible for an additional \$15 charge for any check or debit which is returned or dishonored by the bank as non-payable to Anthem for any reason.

Important: If you are enrolled in an automated billing program, you must give us at least thirty (30) days advance written notice to:

- change banks or credit cards
- change account numbers
- change account names
- stop deductions, or
- re-start eligible deductions.

If we do not receive your request at least thirty (30) days in advance of your premium due date, we will not be able to make the requested change in time to coincide with your premium due date. To make a change, just call us at (800) 317-9818.

Electronic Funds Transfer: If you receive billing statements by mail and you submit a personal check for premium payments, you automatically authorize Anthem to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on your bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting your paper check into an electronic payment does not authorize us to deduct premiums from your account on a monthly basis unless you have given us prior authorization to do so.

Premiums are established based on your Attained Age and the specific regional area within which you live. If you move (change where you reside), you may be subject to a change in premiums. Such change in premiums will be effective on the next billing date following written notification of the change of residence. If you do not notify us and we later learn of the change in residential address, we may adjust the premium retroactively. This means that we may bill you, for any additional premium from the date your address changed. Anthem is not required to notify a Policyholder of a premium increase when a Policyholder enters into a new age bracket. Any change in premiums when a Policyholder enters into a new age bracket will be effective on the next billing date. If a Policyholder's premium is paid beyond the effective date of the change, Anthem may require that the Policyholder pay any additional premium, or accept a refund, whichever is necessary. If the age is misstated, all amounts payable for the correct age shall be adjusted and billed to the Policyholder.

We reserve the right to change the premiums on sixty- (60) day's advance written notice to the Policyholder prior to the effective date of the change. The change will become effective on the date shown in the notice, and payment of the new premium will indicate acceptance of the change.

This Policy will terminate upon failure to pay premiums when due. A grace period of thirty-one (31) days will be allowed for the payment of premiums. If the premiums are not paid within this thirty-one (31) day grace period, termination will be retroactive to the last date of the period for which premium has been paid. We will not pay for any services provided on or after the date of termination. Any claims paid after termination will be retroactively adjusted.

DURATION OF YOUR POLICY

The Effective Date of your coverage is printed on your Anthem identification card, which is issued together with this Policy and is a part of this Policy.

The duration of your coverage under this Policy depends on how your premiums are billed, and is equal to the length of time between billing cycles. For example, if we bill premiums on a bi-monthly basis, your coverage is for a two-month duration. If we bill premiums on a quarterly basis, your coverage is for a three-month duration. If you have chosen Anthem's monthly checking account deduction program, or if we otherwise bill premiums on a monthly basis, your coverage is for a one-month duration. The duration of the Policy is determined by how you pay your premiums (measured from the Effective Date of coverage) and is unrelated to, and is not affected by, the use of other periods of time to measure or determine your rights or benefits, such as, for example, the use of a calendar year or other Deductibles.

Although your Policy expires at the end of each billing cycle, it will, upon timely payment of the billed premiums, automatically renew under the same terms and conditions unless: (1) Anthem has terminated, canceled, or declined to renew the Policy pursuant to the section entitled HOW YOUR COVERAGE ENDS below; or (2) Anthem has modified the Policy pursuant to the section entitled NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY below. In the case of a modification under the section entitled NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY, the Policy will renew for the term specified in the paragraph above.

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HOW YOUR COVERAGE ENDS

Anthem may, at any time, terminate, cancel or decline to renew this Policy in the event of any of the following:

- When your premium is not paid within the grace period. The grace period for payment of future premiums is thirty-one (31) days. If you fail to pay the premiums as they become due, Anthem will terminate this Policy as of the last day through which premium has been paid. If this Policy is terminated for non-payment of premiums, your Policy may be reinstated. See the section Reinstatement in the PART called IMPORTANT INFORMATION ABOUT YOUR PLAN for the reinstatement provision.
- On the last day of the month following our receipt of your written notice to cancel.

Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact. The preceding actions on the application may result in termination or rescission of this Policy. This Policy may also be terminated if you knowingly participated in or permitted fraud or deception by any provider, vendor or any other person associated with this Policy. Termination for any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give 30 days written notice to you prior to rescission of this Policy.

- For fraud or deception in the submission of claims or use of services or facilities or if you knowingly permit such fraud or deception by another. Termination is effective on the date of mailing the written notice.
- Upon your death.
- When you become a permanent Resident outside of Nevada.

NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY

Before Anthem will cease to provide any new or existing individual health benefit Policy:

- We will give you at least 180 days written notice prior to cessation of this Policy, and
- Those individual health benefit policies that are in effect shall not be cancelled for 180 days, after the date of notification to cease coverage, except for specific non-compliance as previously stated under the section HOW YOUR COVERAGE ENDS in this Part.
- When the insurance commissioner finds that the continuation of the coverage would not be in the best interest of the Policyholder or the coverage is obsolete or would impair Anthem's ability to meet its contractual obligations.
- In addition to the right to terminate, cancel or decline to renew the Policy set forth in HOW YOUR COVERAGE ENDS, Anthem has the right upon renewal, to modify or otherwise change the terms and conditions of your Policy, including premiums, as allowed by Nevada.
- Any written notice will be officially given by Anthem when it is mailed to your address as it appears on Anthem's records.

SERVICES NOT COVERED AFTER TERMINATION

Anthem will not cover any services provided after your coverage ends even if Preservice Review was received. Benefits cease on the date your coverage ends as described above. You will be liable for benefit payments made by Anthem on your behalf for services provided after your coverage has terminated, even if the termination was retroactive.

PART 3 HOW YOUR PLAN WORKS WHEN YOU NEED CARE

For more information about specific benefits and your payment responsibility, please see the PARTS called BENEFITS SUMMARY and WHAT IS COVERED.

WHEN YOU GO TO THE DOCTOR FOR AN OFFICE VISIT

If you need to see a Physician, you pay a \$20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year when you go to a PPO Provider. Your Copayment pays for the Office Visit and Covered Services that you receive in your Physician's office during that Office Visit.

After you use these first four (4) Office Visits in a calendar Year, you will need to satisfy your Deductible before we will pay for subsequent Office Visits. But, after your Deductible has been satisfied, you don't pay any Copayment or Coinsurance for Covered Services that you receive during an Office Visit for the remainder of that calendar Year. For information about your payment responsibility if you use a Participating or Non-Participating Provider, see the PART called BENEFITS SUMMARY. Please keep in mind that the first four (4) Office Visits in a calendar Year are combined for all types of services which provide for an Office Visit, combined for PPO, Participating and Non-Participating Providers.

WHEN YOU NEED CARE FOR A MEDICAL EMERGENCY

If you need to go to an emergency room, you pay a \$100 Copayment for care you receive from a PPO or Participating Provider for each emergency room visit. Your Copayment pays for all Covered Services that you receive during that emergency room visit. Also, this Copayment is waived if the emergency room visit results in an inpatient admission into a Hospital immediately following the emergency room services. For your payment responsibility if you see a Non-Participating Provider see the PART called BENEFITS SUMMARY. Once you are stabilized, ongoing care and treatment is not emergency care. Continuation of care from a Non-Participating Provider beyond what is needed to evaluate and/or stabilize you will be paid subject to our Maximum Benefit Allowance and the Out-of-Network cost sharing requirements.

We cover emergency services necessary to screen and stabilize you without preauthorization if a prudent layperson 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. **Follow-up care received in an emergency department or urgent care center, including but not limited to, removal of stitches and dressing changes, are not considered emergency care.** By choosing an urgent care center when appropriate instead of an emergency room, you may reduce out-of-pocket expenses.

IF YOU NEED YOUR EYES CHECKED

If you need to have your eyes checked or receive other vision services and supplies, such as eyeglasses or contact lenses, we'll pay up to a maximum amount of \$50 in each calendar Year.

IF YOU'RE CONSIDERING SURGERY OR OTHER SERVICES

If you're considering surgery or you need other Covered Services, you will have to satisfy your Deductible first before we will provide payment. However, remember that while you're covered under this Policy, you can always take advantage of amounts (called the Contracted Amount) that we have negotiated with our network of PPO and Participating Providers.

Other things to keep in mind:

WHAT ARE COPAYMENTS AND COINSURANCE

Copayment is a fixed dollar amount per day or per visit, which you are responsible to pay to a Provider for the Covered Services that are described in this Policy.

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Coinsurance is a percentage of Allowable Charge that you are responsible to pay for the Covered Services that are described in this Policy. Your Coinsurance is based on our determination of the Allowable Charge and after we subtract any discount that we may have negotiated with the Provider.

Copayments and Coinsurance can also be a combination of a fixed dollar amount and a percentage of Allowable Charge. See the PART called BENEFITS SUMMARY to determine your Copayment and Coinsurance amounts for PPO, Participating and Non-Participating Providers.

Some Copayments and Coinsurance **will not** be applied toward your out-of-pocket maximum and Deductible and **will continue to be required** even after your out-of-pocket maximum and Deductible have been satisfied. See the section What Is Your Out-of-Pocket Maximum in this PART and the PART called BENEFITS SUMMARY for a list of these Copayments and Coinsurance amounts.

WHAT YOU PAY BEFORE YOU MEET YOUR DEDUCTIBLE

For the following Covered Services your Deductible is waived, which means you can get these services without paying your Deductible first, but you will be responsible for any Copayments and Coinsurance that apply.

- The first four (4) Office Visits in a calendar Year
- Emergency room services
- Ambulance services
- Vision benefits (up to the maximum Anthem payment of \$50 in a calendar Year)
- Preventive care services

Generic Prescription Drugs, as explained in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS, are not subject to the Deductible.

For other Covered Services, we will provide payment after you first satisfy your \$5,000 Deductible in each calendar Year. Until your \$5,000 Deductible has been satisfied, you will pay 100% of the Contracted Amount for Covered Services that you receive from PPO and Participating Providers, and you will pay 100% of all charges for Covered Services that you receive from Non-Participating Providers.

WHAT IS YOUR DEDUCTIBLE

Deductible is the amount that you will pay before we begin to pay for certain Covered Services. However, you can receive benefits for the Covered Services listed in the above bullet points without paying your Deductible first. Before we provide payment for other Covered Services, you will need to first satisfy your \$5,000 Deductible in each calendar Year. Only Covered Services based on the Allowable Charge will apply toward your Deductible. Allowable Charge is explained in this PART under How Allowable Charge Is Determined. This Deductible is not prorated for a partial calendar Year.

Once your \$5,000 Deductible has been satisfied in a calendar Year, no further Deductible will be required for the remainder of that calendar Year. In addition, for the remainder of that calendar Year:

- you will not have any Copayment or Coinsurance responsibility for Covered Services that you receive from PPO Providers, except as explained in the PART called BENEFITS SUMMARY;
- you will pay Copayments and Coinsurance for Covered Services that you receive from Participating and Non-Participating Providers as explained in the PART called BENEFITS SUMMARY; and
- you will continue to be required to pay amounts described in the section What Is Your Out-of-Pocket Maximum.

A claim must be submitted in order for us to record your eligible Deductible expense. We will record payments against your Deductible in our files in the order in which your claims are processed, not necessarily in the order in which you receive the service or supply. If you submit a claim for services which have a maximum payment limit (for example, Physical and/or Occupational Therapy and Chiropractic Care performed by a Non-Participating Physician, or Mental Health Conditions) and your Deductible has not been satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Deductible.

Amounts that are applied to your calendar Year Deductible for Covered Services that you receive from Participating and Non-Participating Providers **will** apply toward your out-of-pocket maximum for Participating and Non-Participating Providers.

Amounts paid for the first four (4) Office Visits in a calendar Year, emergency room services, ambulance services and preventive care services will not be applied to your Deductible. Benefits under the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS are not subject to this calendar Year Deductible.

WHAT IS YOUR OUT-OF-POCKET MAXIMUM

Out-of-pocket maximum is the maximum amount that you pay in a calendar Year. After you pay the out-of-pocket maximum, you do not need to pay Copayments or Coinsurance for Covered Services for the remainder of that calendar Year. However, there are a few exceptions, which are explained in the “Exception” section below. Only Covered Services up to the Allowable Charge will be applied to your out-of-pocket maximum for Covered Services. Allowable Charge is explained in the section called How Allowable Charge Is Determined located at the end of this PART.

For **PPO Providers**, your Deductible is the out-of-pocket maximum amount. Once you have satisfied your \$5,000 Deductible in a calendar Year, for the remainder of that calendar Year you will not have any Copayment or Coinsurance responsibility for Covered Services that you receive from PPO Providers, except as explained in the PART called BENEFITS SUMMARY and the “Exception” section below.

For **Participating Providers** and **Non-Participating Providers**, your out-of-pocket maximum is \$10,000 per calendar Year. Once you have satisfied your out-of-pocket maximum in a calendar Year, no further Copayment or Coinsurance will be required for Participating and Non-Participating Providers for Covered Services for the remainder of that calendar Year, except as explained in the “Exception” section below. Amounts applied to your calendar Year Deductible for Covered Services that you receive from Participating and Non-Participating Providers will apply towards your calendar Year out-of-pocket maximum.

Exception: For certain Covered Services, which are described below, you will continue to be required to pay Copayments and Coinsurance and any applicable charges (for example, charges in excess of the Allowable Charge) even after your out-of-pocket maximum and Deductible have been satisfied. Also, amounts you pay for Covered Services, as listed below, will **not** accumulate toward satisfying your out-of-pocket maximum for Participating and Non-Participating Providers.

■ **For PPO Providers, Participating Providers and Non-Participating Providers:**

- Emergency room services
- Ambulance services
- Vision benefits
- Preventive care services
- Additional amounts for not obtaining Preservice Review

■ **For Non-Participating Providers:**

- Physical Therapy
- Occupational Therapy
- Chiropractic Care
- Charges over what Anthem allows as Maximum Benefit Allowance

Copayments and/or Coinsurance amounts paid for the first four (4) Office Visits in a calendar Year, emergency room services, ambulance services and preventive care services will not be applied to the Deductible and out-of-pocket maximum.

Benefits described in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS are not subject to the Deductible. Generic Prescription Drug Copayments/Coinsurance are not applied to the Deductible or out-of-pocket maximum and will continue to be required even after the Deductible and out-of-pocket maximums have been satisfied.

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HOW ALLOWABLE CHARGE IS DETERMINED

Reimbursement for benefits paid under this coverage, except as provided below, is limited to the Allowable Charge. The Allowable Charge is the dollar amount determined and approved by us for Covered Services and procedures. Your applicable cost sharing requirements are based on the Allowable Charge.

For PPO and Participating Providers, the Allowable Charge is the Contracted Amount. PPO and Participating Providers have signed agreements to accept the Contracted Amount as payment in full. The contracts between Anthem and its Providers include a “hold harmless” clause that provides that you cannot be liable to the Provider for moneys owed by Anthem for health care services covered under this Policy.

For Non-Participating Providers, the Allowable Charge is the Maximum Benefit Allowance. You must pay any difference between our Maximum Benefit Allowance and the Non-Participating Provider’s billed charge, except as provided below.

NOTE: We will reimburse Covered Services received from a Non-Participating Provider on the basis of billed charges rather than Maximum Benefit Allowance in the following circumstances:

- **Emergency care (where rendered either within or outside the State of Nevada)**
- **Where in-patient Hospital care at a Non-Participating Provider is necessary due to the nature of the treatment. In this situation an Authorized Referral is required.**
- **Where in-patient Hospital care at a Non-Participating Provider is necessary due to Participating Provider Hospital capacity. In this situation an Authorized Referral is required.**

In all other situations the Maximum Benefit Allowance does apply.

Also review this PART and the PARTS called BENEFITS SUMMARY and WHAT IS COVERED for any per day, visit, calendar Year or lifetime limitations.

When services or supplies are received from a PPO or Participating Provider:

The Contracted Amount is the amount negotiated with the Provider in advance by Anthem. Since the PPO or Participating Provider has agreed to accept the Contracted Amount as payment in full, you will not be responsible for any amount billed in excess of the Contracted Amount. However, you are responsible for any applicable Deductible, Copayments or Coinsurance payments. Also, you are always responsible for services or supplies not covered in this Policy.

When services or supplies are received from a Non-Participating Provider:

Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use PPO or Participating Providers. Since the Non-Participating Provider has not agreed to accept the Maximum Benefit Allowance as payment in full, the amount billed by the Non-Participating Provider may exceed the Maximum Benefit Allowance. You will need to pay that excess amount, in addition to any applicable Deductible, Copayments or Coinsurance payment required. You are always responsible for services or supplies not covered under this Policy.

PART 4 BENEFITS SUMMARY

The benefits described below are provided for Covered Services incurred for treatment of a covered illness, injury or condition. These benefits are subject to all provisions of this Policy, including the PART called WHAT IS COVERED, which may limit benefits or result in benefits not being payable. Any limits on the number of visits or days covered are stated under the specific benefit.

For the following Covered Services, your Deductible is waived, which means you can get these services without paying your Deductible first, but you will be responsible for any Copayments and Coinsurance that apply:

- The first four (4) Office Visits in a calendar Year
- Emergency room services
- Ambulance services
- Vision benefits (up to the maximum Anthem payment of \$50 in a calendar Year)
- Preventive care services

Generic Prescription Drugs, as explained in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS, are not subject to the Deductible.

For other Covered Services, we will provide payment after you first satisfy your \$5,000 Deductible in each calendar Year. Until your \$5,000 Deductible has been satisfied, you will pay 100% of the Contracted Amount for Covered Services that you receive from PPO or Participating Providers, and you will pay 100% of all charges for Covered Services that you receive from Non-Participating Providers. Once your \$5,000 Deductible has been satisfied, you will pay the Copayment and/or Coinsurance listed below for Covered Services for the remainder of *that* calendar Year.

Please remember that your personal financial costs when using Non-Participating Providers may be considerably higher than when you use PPO or Participating Providers. You will have to pay any part of a Provider's bill that is over the Maximum Benefit Allowance for Non-Participating Providers in addition to any applicable Deductible, Copayments or Coinsurance except as provided in this Policy.

Please keep in mind you also need to read the PARTS called WHAT IS COVERED and WHAT IS NOT COVERED to fully understand what these benefits are. For details about the Deductible, and out-of-pocket maximum check the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE. In addition, look at the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS for comprehensive Generic Prescription Drug benefits.

Questions? Visit our web site tonikhealth.com or call customer service **1-800-317-9818**

BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

| YOUR MEDICAL BENEFITS | IN-NETWORK | | OUT-OF-NETWORK | | INFORMATION YOU SHOULD KNOW |
|------------------------------|---------------------------|---------------------------|----------------------------|----------------------------|--|
| | PPO PROVIDER | PARTICIPATING PROVIDER | PARTICIPATING PROVIDER | NON-PARTICIPATING PROVIDER | |
| DEDUCTIBLE | | \$5,000 per calendar Year | | | <p>Amounts paid for the first four (4) Office Visits in a calendar Year, emergency room services, ambulance services, vision benefits (up to Anthem's maximum \$50 payment) and preventive care services are not subject to your Deductible.</p> <p>Please see the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE for more information.</p> |
| OUT-OF-POCKET MAXIMUM | \$5,000 per calendar Year | | \$10,000 per calendar Year | | <p>Amounts paid for certain services will not be applied to your out-of-pocket maximum, including the first four (4) Office Visits in a calendar Year, emergency room services, ambulance services, vision care, preventive care services, and the additional amount for not obtaining Preservice Review.</p> <p>Amounts paid for services received from Non-Participating Providers for physical therapy, occupational therapy and/or chiropractic care will not be applied to your out-of-pocket maximum.</p> <p>Please check the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE for more information.</p> |

BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

| YOUR MEDICAL BENEFITS | IN-NETWORK | | OUT-OF-NETWORK | | INFORMATION YOU SHOULD KNOW |
|------------------------------|---|--|---|--|---|
| | PPO PROVIDER | PARTICIPATING PROVIDER | NON-PARTICIPATING PROVIDER | | |
| OFFICE VISITS | <p>You pay a \$20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all charges up to the Contracted Amount.</p> <p>After your Deductible has been satisfied, you do not pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year.</p> | <p>You pay 30% of Contracted Amount per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all charges up to the Contracted Amount.</p> <p>After your Deductible has been satisfied, you pay 30% of Contracted Amount for the remainder of that calendar Year.</p> | <p>You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all billed charges.</p> <p>After your Deductible has been satisfied, you pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance for remainder of that calendar Year.</p> | | <p>No Deductible is required for the first four (4) Office Visits (professional and preventive care Office Visits combined), PPO, Participating and Non-Participating Providers combined, per calendar Year.</p> <p>Covered Services, including routine physical exams, preventive care, Urgent Care in the Physician's office or Urgent Care Facility, and professional services that you receive in your Physician's office during the Office Visit, are covered under this benefit.</p> <p>Copayments and Coinsurance paid for the first four (4) Office Visits in a calendar Year will not be applied to the Deductible or out-of-pocket maximum.</p> |
| PROFESSIONAL SERVICES | <p>You do not pay any Coinsurance.</p> | <p>You pay 30% of Contracted Amount.</p> | <p>You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance.</p> | | <p>This benefit is separate from professional services covered under the Office Visit benefit (see above) and includes benefits for diagnostic X-ray and laboratory services which are not received during your Physician's Office Visit.</p> <p>Refer to the section Professional Services under the PART called WHAT IS COVERED for a detailed description of Covered Services under this benefit.</p> |

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BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

| YOUR MEDICAL BENEFITS | IN-NETWORK | | OUT-OF-NETWORK | | INFORMATION YOU SHOULD KNOW |
|---|---|---|---|---|---|
| | PPO PROVIDER | PARTICIPATING PROVIDER | NON-PARTICIPATING PROVIDER | | |
| EMERGENCY CARE IN AN EMERGENCY ROOM | You pay a \$100 Copayment for each emergency room visit. This Copayment covers the emergency room visit and Covered Services that you receive in the emergency room during that visit. | You pay a \$100 Copayment for each emergency room visit. This Copayment covers the emergency room visit and Covered Services that you receive in the emergency room during that visit. | You pay a \$100 Copayment for each emergency room visit. This Copayment covers the emergency room visit and Covered Services that you receive in the emergency room during that visit. | | No Deductible is required. Your \$100 Copayment is waived if the emergency room visit results in an inpatient admission into a Hospital immediately following the emergency room services. The \$100 Copayment amount will not be applied to the Deductible or out-of-pocket maximum, and you will continue to be responsible for the Copayment amount after your Deductible and out-of-pocket maximum have been satisfied. |
| INPATIENT HOSPITAL | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | | For Severe Mental Illness, please see this PART and the PART called WHAT IS COVERED for details. |
| OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | | For Severe Mental Illness, please see this PART and the PART called WHAT IS COVERED for details. |
| VISION | | | | You pay all charges except \$50 per calendar Year. | No Deductible is required. Amounts paid do not apply to the Deductible or out-of-pocket maximum. Covered Services received under this benefit are separate from Covered Services received under any other benefit described in this Policy. For a description of Covered Services, please see the Vision section in the PART called WHAT IS COVERED. |

BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

| YOUR MEDICAL BENEFITS | OUT-OF-NETWORK | | INFORMATION YOU SHOULD KNOW |
|--|--|--|---|
| | IN-NETWORK PPO PROVIDER | PARTICIPATING PROVIDER | |
| <p>PREVENTIVE CARE Preventive Care Services in this section shall meet requirements as determined by federal and state law. These services fall under four broad categories as shown below:</p> <ol style="list-style-type: none"> Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: <ul style="list-style-type: none"> Breast cancer; Cervical cancer; Colorectal cancer; High Blood Pressure; Type 2 Diabetes Mellitus; Cholesterol; Child and Adult Obesity. | <p>Many In-Network preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member. That means Anthem pays 100% of the Allowable Charge</p> | <p>Office Visits: You pay 30% of Contracted Amount per Office Visit . For subsequent Office Visits, you pay all charges up to the Contracted Amount. After your Deductible has been satisfied, you pay 30% of Contracted Amount for the remainder of that calendar Year. Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you pay 30% of Contracted Amount.</p> | <p>For services received from Out-of-Network providers, no Deductible is required for Office Visits (professional and Preventive Services Office Visits combined), for Participating and Non-Participating Providers combined, per calendar Year. Covered Services, including routine physical exams, preventive care and professional services that you receive in your Physician's office during the Office Visit are covered under this benefit. Copayments and Coinsurance paid to Out-of-Network providers for Office Visits in a calendar Year will not be applied to the Deductible or out-of-pocket maximum. See the PART called WHAT IS COVERED for a full description of covered preventive care services and preventive care services that are not subject to the Deductible.</p> |

Questions? Visit our web site tonikhealth.com or call customer service **1-800-317-9818**

BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

| YOUR MEDICAL BENEFITS | IN-NETWORK | | OUT-OF-NETWORK | | INFORMATION YOU SHOULD KNOW |
|--|--------------|------------------------|------------------------|----------------------------|-----------------------------|
| | PPO PROVIDER | PARTICIPATING PROVIDER | PARTICIPATING PROVIDER | NON-PARTICIPATING PROVIDER | |
| <p>2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;</p> <p>3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and</p> <p>4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration</p> | | | | | |

BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

| YOUR MEDICAL BENEFITS | IN-NETWORK | | OUT-OF-NETWORK | | INFORMATION YOU SHOULD KNOW |
|---|---------------------------------|-----------------------------------|--|--|--|
| | PPO PROVIDER | PARTICIPATING PROVIDER | NON-PARTICIPATING PROVIDER | | |
| PHYSICAL THERAPY OCCUPATIONAL THERAPY AND/OR CHIROPRACTIC CARE | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | | <p>Benefits are limited to 12 visits per calendar Year combined for Physical Therapy, Occupational Therapy and/or Chiropractic Therapy; PPO, Participating and Non-Participating Providers combined.</p> <p>Note: If Anthem determines that an additional period of Physical Therapy, Occupational Therapy and/or Chiropractic Care is both Medically Necessary and likely to result in a significant improvement to your condition during that period of additional care, Anthem will authorize a specific number of additional visits.</p> <p>Payments for Non-Participating Providers will not be applied to your out-of-pocket maximum, and you will continue to be required to pay these amounts even after your out-of-pocket maximum has been satisfied.</p> |
| DENTAL SERVICES UNDER THIS POLICY | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | | |

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BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

| YOUR MEDICAL BENEFITS | IN-NETWORK | | OUT-OF-NETWORK | | INFORMATION YOU SHOULD KNOW |
|-------------------------------------|---|---|---|--|--|
| | PPO PROVIDER | PARTICIPATING PROVIDER | NON-PARTICIPATING PROVIDER | | |
| AMBULANCE | You pay \$100 Copayment per day for ground and/or air ambulance services. | You pay \$100 Copayment per day for ground and/or air ambulance services. | You pay \$100 Copayment per day for ground and/or air ambulance services. | | No Deductible is required for ambulance services. Copayments amounts will not be applied to the Deductible or out-of-pocket maximum, and you will continue to be responsible for payment after your Deductible and out-of-pocket maximum have been satisfied. |
| SEVERE MENTAL ILLNESS | Benefits provided the same as for any other medical condition. | Benefits provided the same as for any other medical condition. | Benefits provided the same as for any other medical condition. | | Anthem will cover benefits up to a maximum of 40 full inpatient days or 80 partial inpatient days per calendar Year; and 40 outpatient visits per calendar Year. Please see the PART called WHAT IS COVERED for details. |
| ALCOHOL AND DRUG ABUSE | Benefits provided the same as for any other medical condition. | Benefits provided the same as for any other medical condition. | Benefits provided the same as for any other medical condition. | | |
| PROGRAMS TO STOP TOBACCO USE | Anthem will cover smoking cessation programs designed to end the dependence on nicotine as determined by federal and state law. Covered benefits apply to in network services only. Anthem pays 100% of the Allowable Charge. | | Not covered | | |

BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

| YOUR MEDICAL BENEFITS | IN-NETWORK | | OUT-OF-NETWORK | | INFORMATION YOU SHOULD KNOW |
|--|---|-----------------------------------|--|--|--|
| | PPO PROVIDER | PARTICIPATING PROVIDER | NON-PARTICIPATING PROVIDER | | |
| OTHER ELIGIBLE PROVIDERS Such as: Blood Bank Dentist (D.D.S.) Dispensing Optician Respiratory Therapist (except as provided for under Home Health Care) | You pay all charges in excess of the Maximum Benefit Allowance. | | | | These Providers do not enter into Participating agreements with us, and they must be licensed according to state and local laws to provide Covered Services. Covered Services received from a dispensing optician under this benefit are separate from Covered Services received from a dispensing optician under the "Vision" benefit. |
| MEDICAL SUPPLIES MEDICAL EQUIPMENT AND FOOTWEAR | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | | Footwear is limited to a maximum Anthem payment of \$400 per calendar Year; PPO, Participating and Non-Participating Providers combined. For more information see the section Medical Supplies and Medical Equipment under the PART called WHAT IS COVERED. |
| FOREIGN COUNTRY PROVIDERS | For initial treatment of a Medical Emergency only. You pay a \$100 Copayment plus 30% after Deductible of billed charges for each emergency visit. | | | | You are responsible, at your expense, for obtaining an English language translation of foreign country Provider claims and medical records. |
| HOME HEALTH CARE | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | | Limited to 60 visits per calendar Year, up to 4 hours each visit; PPO, Participating and Non-Participating Providers combined. |
| INFUSION THERAPY | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | | |

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BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

| YOUR MEDICAL BENEFITS | OUT-OF-NETWORK | | INFORMATION YOU SHOULD KNOW |
|--|---|---|--|
| | IN-NETWORK PPO PROVIDER | PARTICIPATING PROVIDER | |
| HOSPICE | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. See Hospice under the PART called WHAT IS COVERED for additional information. |
| SPECIAL CIRCUMSTANCES FOR AUTHORIZED REFERRAL | This benefit does not apply to PPO Providers. | This benefit does not apply to Participating Providers. | Non-Participating Providers: Professional Providers, Hospital (inpatient or outpatient), Ambulatory Surgical Center. Please see the PART called IMPORTANT TERMS TO KNOW for information about Authorized Referrals. |
| ELECTIVE SERVICES OUTSIDE NEVADA BLUECARD PROGRAM | | | For emergency care see the information above under Emergency Care In An Emergency Room. |
| PROFESSIONAL | BlueCard PPO Provider: You do not pay any Coinsurance. | BlueCard Traditional Provider: You pay 30% of the BlueCard Provider's Negotiated Price.* | For information about the BlueCard Program, including descriptions of the types of Providers you may encounter outside Nevada (i.e., PPO, Traditional and Non-Participating Providers), please see the PART called WHEN YOU TRAVEL OUTSIDE NEVADA . |
| HOSPITAL OR AMBULATORY SURGICAL CENTER | BlueCard PPO Provider: You do not pay any Coinsurance. | BlueCard Traditional Provider: You pay 30% of the BlueCard Provider's Negotiated Price.* | Please be advised that BlueCard PPO Providers are different than Anthem PPO Providers. *If there are no BlueCard PPO Providers where you are receiving care outside of Nevada, you do not pay any Coinsurance. |

YOUR PAYMENT – NO DEDUCTIBLE REQUIRED

| Your Generic Prescription Drug Benefits | When You Go To A Participating Pharmacy | When You Go To A Non-Participating Pharmacy | INFORMATION YOU SHOULD KNOW |
|---|---|--|---|
| <p>PRESCRIPTION DRUG COVERAGE</p> <p>Retail Pharmacies:</p> <p>Generic Drugs Including insulin and metabolic foods</p> | <p>You pay a \$10 Copayment for each Prescription and/or refill for each 34-day supply.</p> | <p>You pay the full cost of the Prescription, we will reimburse you less a \$10 Copayment plus 30% of the billed charge for each Prescription and/or refill for each 34-day supply.</p> | <p>Your Prescription Drug benefit (including mail service Prescription Drugs) covers only Generic Prescription Drugs listed on the Anthem Generic Prescription Drug List/Formulary.</p> <p>Metabolic foods are covered for inherited enzymatic disorders up to an Anthem maximum payment of \$2,500 per calendar Year as described under the Food and Nutrition section in the PART called WHAT IS COVERED.</p> <p>Outpatient Generic Prescription Drug benefits are separate from your medical benefits.</p> |
| <p>Self-Administered Injectable Drugs</p> | <p>You pay 30% of the Contracted Amount for Drugs listed on the Anthem Generic Prescription Drug List/Formulary, except for insulin.</p> | <p>You pay the full cost of the Prescription, we will reimburse you less 30% of the Maximum Benefit Allowance for Drugs listed on the Anthem Generic Prescription Drug List/Formulary, except for insulin.</p> | <p>This is just a brief description of your Prescription Drug benefits; for detailed information, including exclusions, limitations and conditions of coverage, please see the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.</p> <p>For information on how to file a claim if you go to a Non-Participating pharmacy, please see the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.</p> |
| <p>When You Order By Mail:</p> <p>Generic Drugs</p> | <p>You pay a \$10 Copayment for each Prescription and/or refill for each 34-day supply or a \$20 Copayment for up to a maximum 90-day supply.</p> | <p>Not Applicable.</p> | |

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PART 5 WHAT IS COVERED

COVERED SERVICES

Described below are the types of services covered under this Policy for the treatment of a covered illness, injury or condition.

Remember, for the following Covered Services your Deductible is waived, which means you can get these services without paying your Deductible first, but you will be responsible for any Copayments and Coinsurance that apply:

- The first four (4) Office Visits in a calendar Year
- Emergency room services
- Ambulance services
- Vision benefits (up to the maximum Anthem payment of \$50 in a calendar Year)
- Preventive care services

Generic Prescription Drugs, as explained in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS, are not subject to the Deductible.

All other Covered Services are subject to the calendar Year Deductible including any limited benefits. The medical Deductible is described in the Deductible section in the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE.

Before you review this list of Covered Services take a moment to review the definition of Allowable Charge. Knowing the meaning of this term will greatly assist you in determining the benefits of this Policy and your Copayment and/or Coinsurance responsibility.

Another term you should become familiar with is Preservice Review. Preservice Review begins when your Physician provides medical information to us prior to a specific service or procedure taking place so that we can determine if it is Medically Necessary and a Covered Service. The PART called UTILIZATION MANAGEMENT AND PRESERVICE REVIEW PROCEDURES describes what services require Preservice Review and how to obtain Preservice Review, or you can also go to our website at anthem.com for information on what services require Preservice Review. When Preservice Review is required but not obtained, you will be responsible for an additional amount which will be the lesser of \$250 or 50% of the allowed amount if Preservice Review is not obtained by your Physician.

PROFESSIONAL SERVICES

- Services of a Physician, including surgeons and specialists.
- Services of an anesthesiologist or anesthesiologist.
- Outpatient diagnostic radiology and laboratory services. Specific diagnostic radiology and laboratory services require Preservice Review.
- Radiation therapy and hemodialysis treatment.
- Surgical implants.
- Artificial limbs or eyes.
- Reconstruction of a breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are covered for physical complications for all stages of mastectomy. If you choose not to have surgical reconstruction after a mastectomy, we will provide coverage for an external prosthesis.
- The first pair of contact lenses or eyeglasses, when required as a result of covered eye surgery.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products. Autologous blood donations will be covered only when the blood is transfused back into the patient.
- Injectable contraceptives, except Norplant, when administered in a Physician's office.
- FDA approved medications that may be dispensed only by a Physician.

- Hepatitis B and Varicella Zoster (chicken pox) vaccines and other appropriate vaccinations as recommended by the American Academy of Pediatrics for the Policyholder age 0 through 18 and the Office Visit associated with administering that vaccination when ordered by your Physician.
- Reconstructive Surgery, which is defined as Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by Congenital Defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance to the extent possible. If the Reconstructive Surgery is for a mastectomy and the surgery is started within three years after a mastectomy, benefits will be at least equal to the benefits at the time of the mastectomy. If the Reconstructive Surgery has started more than three years after the mastectomy, the benefits provided are subject to the terms of this Policy. Post mastectomy surgical benefits also include augmentation, mammoplasty, reduction mammoplasty, and mastopexy.
- Services of a Provider for diabetes education services.
- Services of a Physician or dentist treating an Accidental Injury to your natural teeth when you receive treatment within one (1) year following the injury. Damage to your teeth due to chewing or biting is not an Accidental Injury.

HOSPITAL

Requires Preservice Review.

- A Hospital room with two or more beds. If a private room is used, we will allow only up to the prevailing two-bed room rate.
- Services in special care units.
- Operating rooms and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology and radiology rendered while in the Facility.
- Drugs and medicines approved by the Food and Drug Administration, including oxygen given to you during your stay, which are supplied by the Hospital for the illness, injury or condition for which you are hospitalized, including take home Drugs billed on your inpatient Hospital bill and dispensed by the Hospital's Pharmacy at the time of your discharge from the Hospital.
- Use of the emergency room.
- Outpatient services and supplies, including those in connection with outpatient surgery performed at an Ambulatory Surgical Center.
- Outpatient Day Treatment Program services when rendered at a psychiatric Facility.
- Long-term acute care is covered for complex medical needs such as low level closed head injuries.
- Reconstruction of a breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are covered for physical complications for all stages of mastectomy. If you choose not to have surgical reconstruction after a mastectomy, we will provide coverage for an external prosthesis.

LIMITED PROFESSIONAL SERVICES

■ Physical Therapy, Occupational Therapy and/or Chiropractic Care:

Physical Therapy, Occupational Therapy and/or Chiropractic Care includes the therapeutic use of heat, cold, exercise, electricity, ultraviolet, manipulation of the spine, massage to improve circulation, strengthen muscles, encourage return of motion, or treatment of illness or injury.

Benefits for Physical Therapy, Occupational Therapy and/or Chiropractic Care are payable only for services rendered by a Provider. Benefits for these services are limited to 12 visits per calendar Year combined for PPO, Participating and Non-Participating Providers, **except** for treatment for the following:

- Post neurological surgery
- Orthopedic surgery
- Cerebral vascular accident
- Third degree burns

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- Head trauma
- Spinal cord injury

These services are limited to a maximum of 24 visits per calendar Year.

Note: If Anthem determines that an additional period of Physical Therapy, Occupational Therapy and/or Chiropractic Care is both Medically Necessary and likely to result in a significant improvement to your condition during that period of additional care, Anthem will authorize a specific number of additional visits.

- **Outpatient Speech Therapy When Following Surgery, Injury or Non-Congenital Organic Disease:** Benefits are limited to 50 visits per calendar Year. We will not pay for more than 50 visits maximum per calendar Year unless authorized by Anthem in advance of the services being rendered. If Anthem determines that an additional period of speech therapy is both Medically Necessary and likely to result in a significant improvement to the Policyholder's condition during that period of additional care, Anthem will authorize a specific number of additional visits.
- **Footwear services** in relation to preparation and dispensing of custom footwear necessary to treat an injury or illness. Limited to a maximum Anthem payment of \$400 per calendar Year combined for PPO, Participating and Non-Participating Providers.

VISION

We will pay up to a maximum of \$50 per calendar Year for vision services, such as a routine eye exam, eyeglasses or contact lenses, for PPO, Participating Providers and Non-Participating Providers combined. Covered Services received under this benefit are separate from Covered Services received under any other benefit described in this Policy. You may have to pay for all care received and must submit a claim to Anthem for reimbursement. For information on how to file a claim see the PART called HOW TO USE YOUR HEALTH PLAN.

PREVENTIVE CARE

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member as explained in the *Benefits Summary List*. That means Anthem pays 100% of the Allowable Charge. These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
 - Breast cancer;
 - Cervical cancer;
 - Colorectal cancer;
 - High Blood Pressure;
 - Type 2 Diabetes Mellitus;
 - Cholesterol;
 - Child and Adult Obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

You may call Customer Service using the number on your ID card for additional information about these services.

Covered Preventive Care Services also include the following services required by state and federal law:

Taking advantage of preventive care is important to help keep you healthy. The following preventive care services are available under the Office Visit and Preventive Care benefits as described in the PART called BENEFITS SUMMARY:

For the Policyholder age 19 and above:

- Physical assessment with a health history
- Blood pressure check
- Fingertick cholesterol and glucose measurement check
- Tetanus-diphtheria immunization if none in the previous ten (10) years or when medically appropriate
- Influenza vaccine when medically appropriate
- Counseling and literature on health related issues
- Other medically appropriate tests and procedures as indicated
- Cancer screening tests approved by the federal Food and Drug Administration (FDA) and the Office Visit associated with performing those tests when ordered by your Physician, registered nurse practitioner or certified nurse midwife. This includes screening for cervical, ovarian cancer and colorectal cancer screening.
- Annual pap exam. This service is not subject to the Deductible
- Annual mammogram examinations including the appropriate screening for breast cancer and the Office Visit associated with performing those tests when ordered by your Physician, registered nurse practitioner or certified nurse midwife. This service is not subject to the Deductible.
- Breast exams
- Annual prostate specific antigen (PSA) testing. This service is not subject to the Deductible.

For the Policyholder ages 0 through 18 years:

- Physical assessment with a health history
- Blood pressure check
- Age appropriate laboratory tests
- Vision and hearing tests
- Counseling and literature on health related issues
- Immunization history with shots given based on immunization records
- Other medically appropriate tests and procedures as indicated
- Colorectal cancer screening in accordance with the guidelines published by the American Cancer Society.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition. Benefits and services will be considered under the Diagnostic Services benefit.

See the PART called BENEFITS SUMMARY under the Office Visit and preventive care sections for further information about Covered Services and your payment responsibility.

DENTAL SERVICES UNDER THIS POLICY

- Up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary for dental treatment due to an unrelated medical condition of the Policyholder and has been ordered by a Physician (M.D.) and a dentist (D.D.S.).
- Services of a Physician or dentist treating an Accidental Injury to your natural teeth when you receive treatment within one (1) year following the injury. Damage to your teeth due to chewing or biting is not an Accidental Injury. Benefits are described in the Dental Services Under This Policy section under the PART called BENEFITS SUMMARY.
- General anesthesia and associated Facility charges for dental procedures in a Hospital or surgery center for the Policyholder who is under twenty-four (24) years of age due to:
 - A physical, mental, medically compromising condition;

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- A dental need for which local anesthesia is ineffective because of acute infection or allergy;
- The Policyholder being extremely uncooperative, unmanageable, or uncommunicative; or
- The Policyholder sustains extensive orofacial and dental trauma to a degree that would require unconscious sedation.

Medical or surgical services related to temporomandibular joint therapy or surgery is covered. Services or supplies that are recognized as dental procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints, are not covered.

AMBULANCE

Ground ambulance is usually the preferred method of transportation. If you elect not to receive transport to an emergency Facility after an ambulance has been called, your Deductible, Coinsurance, and/or Copayment will still apply.

- Base charge and mileage expenses to transport you to or from, a Hospital when Medically Necessary.
- Non-reusable supplies.
- Monitoring, electrocardiograms (EKG or ECG), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with the ambulance service. An appropriately licensed person must render the services.
- Payment of benefits for ambulance services will be made directly to the Provider of service unless proof of payment is received by us prior to the benefits being paid.
- Ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if you are not transported to a Hospital.

SEVERE MENTAL ILLNESS

Requires Preservice Review.

This benefit is for treatment of Severe Mental Illness Conditions.

- Services must be for treatment of Severe Mental Illness Conditions, which are schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
- Inpatient Hospital services are limited to forty (40) full days or eighty (80) partial days per calendar Year for PPO, Participating and Non-Participating Providers combined. One full inpatient day is for more than 12 hours of treatment. One partial day is no less than 3 hours and no more than 12 hours of treatment in a day.
- Outpatient Providers' services are limited to forty (40) visits per calendar Year. This includes inpatient or outpatient visits and/or psychological testing.

ALCOHOL AND DRUG ABUSE

Requires Preservice Review.

This benefit is for the withdrawal of the effects of alcohol or drug abuse.

- Treatment for withdrawal from the effects of alcohol or drugs.
- Treatment as an inpatient.
- Counseling if not admitted as inpatient.

PROGRAMS TO STOP TOBACCO USE

We will cover smoking cessation programs designed to end the dependence on nicotine as determined by federal and state law. Covered benefits apply to in network services only. You may have to pay for all care received and must submit a claim to Anthem for reimbursement. For information on how to file a claim see the PART called HOW TO USE YOUR HEALTH PLAN.

MEDICAL SUPPLIES AND MEDICAL EQUIPMENT

Rental, or purchase at Anthem's sole discretion, of dialysis equipment and supplies, and other long-lasting Medical Equipment and Medical Supplies, when:

- Ordered by your Physician, and
- Of no further use when medical needs end, and
- Useable only by the patient, and
- Not primarily for your comfort or hygiene, and
- Not for environmental control, and
- Not for exercise, and
- Manufactured specifically for medical use.

Note: Except as provided in the Footwear benefit under Limited Professional Services, coverage does not include orthopedic shoes or shoe inserts, arch supports, disposable sheaths and supplies, correction appliances or support appliances and supplies such as stockings or personal comfort items as indicated in the PART called WHAT IS NOT COVERED.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. Anthem determines whether the item meets the above conditions.

The equipment or supply must be for medical use to treat a health problem, and only for the use of the Policyholder for whom it was prescribed.

WIGS

We will pay up to \$400 for wigs per Year with a Physician's Prescription.

HOME HEALTH CARE

Home Health Care Providers are included in our PPO and Participating Provider network. The following services of a Home Health Agency are covered for up to 60 visits per calendar Year for PPO, Participating and Non-Participating Providers combined. A visit is defined as four (4) hours or less of service provided by one of the Providers listed below.

- A registered nurse (R.N.) or licensed practical nurse (L.P.N.).
- A licensed therapist for Physical Therapy, Occupational Therapy, speech or respiratory therapy.
- Nutrition counseling by a nutritionist or dietician.
- A medical social service worker.
- A health aide who is employed by, or under arrangement with, a Home Health Agency. A health aide is covered only if you are also receiving the services of a registered nurse or licensed therapist employed by the same organization and the registered nurse is supervising the services.
- Necessary Medical Supplies, prosthesis and orthopedic appliances, rental or purchase of durable Medical Equipment, Drugs, medicines, or insulin when provided by the Home Health Agency.
- Private Duty Nursing when Medically Necessary and approved by Anthem.

Benefits are covered when you are confined at home under the active supervision of your Physician. The Physician must be treating the illness or injury necessitating the Home Health Care and renew the order for these services at least once every thirty (30) days. Providers in Nevada must be a Nevada licensed Home Health Agency.

Note: We will not cover personal comfort items under this Home Health Care benefit. All Home Health Services and Supplies related to Infusion Therapy are included in the Infusion Therapy benefit section.

INFUSION THERAPY

If services are performed in the home, those services must be billed by and performed by a Provider licensed by state and local laws.

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A **Course of Therapy** is defined as Physician prescribed Infusion Therapy for a period of ninety (90) days or less.

Covered Services include:

- Drugs and other substances used in Infusion Therapy.
- Professional services to order, prepare, dispense, deliver, administer, train or monitor, including clinical pharmacy support and any Drugs or other substances used in a Course of Therapy.
- All necessary durable, reusable supplies and durable Medical Equipment including, but not limited to, pump, pole and electric monitor.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.

Infusion Therapy benefits will not be covered for:

- Compounding fees, such as charges for mixing or diluting Drugs, medicines or solutions, or incidental supplies, including disposable items, such as cotton swabs, tubing, syringes and needles for Drugs, adhesive bandages and intravenous starter kits.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled “Caution, limited by federal law to investigational use” or drugs prescribed for experimental use.
- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.
- Charges by a Non-Participating Provider exceeding the Maximum Benefit Allowance.

Note: Medical Supplies and Equipment used in Infusion Therapy will not be reimbursed under any other benefit of this Policy.

TREATMENT FOR DIABETES

Medical services and supplies provided for the treatment of diabetes are paid on the same basis as any other medical condition. Diabetes includes type I, type II and gestational diabetes. Benefits will be covered for the following Covered Services:

Diabetes Equipment and Supplies

- Blood glucose monitors, including monitors designed to assist the visually impaired and blood glucose testing strips
- Insulin Pumps
- Pen delivery systems for insulin administration
- Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes related complications
- Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin

These covered equipment and supplies are covered under your Policy’s benefits for durable Medical Equipment. See the section Medical Supplies, Medical Equipment and Prosthetic Devices under this PART.

Diabetes Outpatient Self-Management Training Program

- Designed to teach the Policyholder, who is a patient, about the disease process and the daily management of diabetic therapy.
- Includes self-management training, education and nutrition therapy to enable you to properly use the equipment, supplies and medications necessary to manage the disease.

Note: Diabetes education services are also covered under this Policy’s benefits. Education services must be rendered by a covered Provider.

Other Services

- Diabetic eye exams (not subject to the vision payment maximum)

As listed on the Anthem Generic Prescription Drug List/Formulary, the following medications and supplies are covered under your Prescription Drug benefits:

- Insulin, glucagon and other Prescription Drugs for the treatment of diabetes
- Insulin syringes
- Urine testing strips and lancets

These items may be obtained from a retail Pharmacy or through the mail service Prescription drug program. See the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.

FOOD AND NUTRITION

Coverage for the testing and treatment of phenylketonuria (PKU) is paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by this Policy. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Enteral nutrition is the delivery of nutrients by a tube into the gastrointestinal tract, nursing visits to assist with enteral nutrition are covered when Medically Necessary and not considered Custodial Care under the Home Health benefits. These services are frequently provided through a Home Health Agency.

Coverage is provided for enteral formulas for use at home that are prescribed or ordered by a Physician as a Medically Necessary treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from Congenital Defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat metabolism. Special food product means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. Special food products do not include food that is naturally low in protein.

ORGAN AND TISSUE TRANSPLANTS

Requires Preservice Review.

Covered Services include heart, liver, lung, heart/lung, kidney, simultaneous pancreas/kidney, pancreas, bone marrow harvest and transplant, including autologous bone marrow transplant, peripheral stem cell replacement, and cornea.

Services are covered in connection with a covered organ or tissue transplant, if you are:

- The organ or tissue recipient, or
- The organ or tissue donor.
- If you are the recipient, an organ or tissue donor who does not have coverage provided by Anthem or its affiliates is also eligible for services as described in this section. Benefits are reduced by any amounts paid or payable by any other source.
- The Policyholder who needs to store cord blood and the storage of the blood is considered Medically Necessary according to the Anthem criteria for cord blood storage at an Anthem designated Provider.

The following **travel expense benefits** will be covered for the recipient or donor in connection with a covered organ or tissue transplant if the specific approved transplant Facility, when approved by Anthem, is 250 miles or more from the recipient's or donor's home. All travel expense benefits must receive authorization by Anthem in advance.

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Travel expenses will be covered for the recipient and one companion per transplant (limited to six (6) trips per transplant). Travel expenses include:

- Transportation to and from the approved transplant Facility not to exceed \$250 per trip for each person for round trip coach airfare.
- Hotel accommodations not to exceed \$100 per day for up to twenty-one (21) days per trip and is limited to one (1) room.
- Meal expenses not to exceed \$25 per day for each person for up to twenty-one (21) days per trip. Tobacco, alcohol and Drug expenses are excluded from coverage.

Travel expenses will be covered for the donor per transplant (limited to one (1) trip per transplant). Travel expenses include:

- Transportation to and from the approved transplant Facility not to exceed \$250 for round trip coach airfare.
- Hotel accommodations not to exceed \$100 per day for up to seven (7) days limited to one (1) room.
- Meal expenses not to exceed \$25 per day up to seven (7) days limited to one (1) person. Tobacco, alcohol and Drug expenses are excluded from coverage.

HOSPICE

To be eligible you must be suffering from a terminal illness for which the prognosis of life expectancy is six (6) months or less as certified by your Physician.

Your Physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan.

To be eligible for this benefit, the Provider must be appropriately licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal illness. The Provider must also be approved as a Hospice Provider under Medicare and licensed by the State of Nevada or by the appropriate agency in the state of Nevada.

Benefits for Home Health services cannot be used at the same time you are receiving Hospice benefits. Medical Supplies and equipment used during Hospice care will not be reimbursed under any other benefit of this Policy.

COMPLICATIONS OF PREGNANCY

Maternity and obstetrical care are not covered regardless of where they are received. Complications of pregnancy are covered for the female Policyholder, which include:

- Conditions (when the pregnancy is not terminated) caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions.
- Conditions (when the pregnancy is terminated) resulting in non-elective cesarean section, ectopic pregnancy, or spontaneous termination of pregnancy.

Complications of Pregnancy do not include services for false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy and not requiring Hospital confinement for medical treatment.

CLINICAL TRIAL OR STUDY SERVICES

Coverage for medical treatment received as part of a clinical trial or study is covered only if all of the following conditions are met:

- The medical treatment is provided in a Phase I, II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

- The clinical trial or study is approved by:
 - An agency of the National Institutes of Health,
 - A cooperative group (a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health),
 - The Food and Drug Administration as an application for a new investigational drug
 - The United States Department of Veterans Affairs, or
 - The United States Department of Defense;
- In the case of a Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or a Phase II, Phase III or Phase IV study of clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a health care provider and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;
- The medical treatment is provided by a health care provider and the facility and personnel have the experience and training to provide the treatment in a capable manner;
- There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;
- The clinical trial or study is conducted in Nevada; and
- You have signed, before your participation in the clinical trial or study, a statement of consent indicating that you have been informed of, without limitation:
 - The procedure to be undertaken,
 - Alternative methods of treatment, and
 - The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

To be eligible for the benefits described in this section, you must submit copies of the following:

- The approval or certification of the clinical trial or study,
- The statement of consent signed by you,
- Protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment pursuant to this section.

Benefits for medical treatment received as part of a clinical trial or study are limited to:

- Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in your medical treatment.
- The cost of any reasonably necessary health care services provided by a Participating Provider that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under this coverage.
- The cost of any routine health care services that would otherwise be covered under this Policy for you in a Phase I clinical trial or study.
- The initial consultation to determine whether you are eligible to participate in the clinical trial or study.
- Health care services provided by a Participating Provider and required for the clinically appropriate monitoring during a Phase II, Phase III or Phase IV clinical trial or study.
- Health care services which are required for your clinically appropriate monitoring during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

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PART 6 WHAT IS NOT COVERED

We will not furnish benefits for the following services and supplies. They are considered to be exclusions and limitations, which include, but are not limited to the following:

ACUPUNCTURE AND ACUPRESSURE

ALTERNATIVE OR COMPLEMENTARY MEDICINES

Services in this category include holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique, clonics or iridology.

BIOFEEDBACK

BREAST REDUCTION

Breast reduction surgery (reduction mammoplasty) or services related to breast reduction surgery, unless the breast reduction surgery is performed because of breast cancer.

CLINICAL TRIALS

- Services for medical treatment received as part of a clinical trial or study described which are provided to you by the sponsor of the clinical trial or study free of charge to you.
- Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.
- Coverage for a drug or device which is paid for by the manufacturer, distributor or provider of the drug or device.
- Health care services that are specifically excluded from coverage under this coverage, regardless of whether such services are provided under the clinical trial or study.
- Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.
- Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that you may incur.
- Any expenses incurred by a person who accompanies you during the clinical trial or study.
- Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management.
- Any costs for the management of research relating to the clinical trial or study.

COMPLICATIONS OF NON-COVERED SERVICES

Complications arising from non-Covered Services and supplies. Examples of non-Covered Services include but are not limited to, Cosmetic Surgery, sex-change operations and procedures, which are determined to be Experimental/Investigational.

COSMETIC SURGERY

or other services that are performed to alter or reshape normal structures of the body in order to improve appearance.

CUSTODIAL CARE

or domiciliary or rest cures for which facilities and/or services of a general acute Hospital are not medically required. Custodial Care is care that does not require the regular services of trained medical or health professionals, such as but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets and supervision of medications which are ordinarily self-administered.

DIAGNOSTIC ADMISSIONS

Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

EDUCATIONAL SERVICES AND NUTRITIONAL COUNSELING

except as specifically covered or arranged by us under the Diabetes Outpatient Self-Management Training Program, provisions in the PART called WHAT IS COVERED.

EXCESS AMOUNTS

Any amounts in excess of the maximum amounts stated in the benefit sections of this Policy. Any amounts in excess of Allowable Charge except as provided herein.

EXPERIMENTAL OR INVESTIGATIONAL

Medical, surgical and/or other procedures, services, products, drugs or devices (including implants), which are Experimental and Investigational Procedures.

FOOD AND/OR DIETARY SUPPLEMENTS

except for formulas and special food products as specifically stated under Food and Nutrition in the PART called WHAT IS COVERED. They must be prescribed by a Physician and deemed Medically Necessary to prevent complications of PKU and other enzymatic disorders. Coverage is only to the extent that the prescribed formulas and special food products exceed the cost of a normal diet.

GENETIC TESTING OR COUNSELING

Preconception, paternity testing, court-ordered genetic counseling and testing, testing for inherited disorders, discussion of family history or testing to determine the sex or physical characteristics of an unborn child.

GOVERNMENT SERVICES

Any services provided by a local, state or federal government agency.

HEARING AIDS

Hearing aids and routine hearing tests unless specified by state or federal law.

INFERTILITY SERVICES

All services related to the evaluation or treatment of Infertility, including all tests, consultations, medications, surgical, medical or laboratory procedures.

INTRACTABLE PAIN OR CHRONIC PAIN

This coverage does not cover services or supplies for the treatment of Intractable Pain and/or chronic pain. Chronic pain is pain of continuous and long-standing duration where the cause cannot be removed.

LEARNING OR BEHAVIORAL THERAPIES**MATERNITY/PREGNANCY CARE**

No benefits are covered for pregnancy, maternity care or elective or therapeutic abortions, except as specifically stated in the section Complications of Pregnancy in the PART called WHAT IS COVERED.

MEDICAL EQUIPMENT AND SUPPLIES

Including but not limited to orthopedic shoes or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, supplies for comfort, hygiene or beautification, disposable sheaths and supplies, correction appliances or support appliances and supplies such as stockings except as specifically stated in the PART called WHAT IS COVERED.

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MENTAL HEALTH CARE

Treatment of Mental Health Care or psychological testing except as specifically stated under the benefit sections (for Severe Mental Illness) in this Policy. **However, medical services provided to treat medical conditions that are caused by behavior of the Policyholder that may be associated with mental or nervous conditions, for example, self-inflicted injuries, are not subject to these limitations.**

NON-DUPLICATION OF MEDICARE

We will not provide benefits that duplicate any benefits you would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which you can enroll without paying additional premium. However, if you have to pay an additional premium to enroll in Part A, B, C, or D of Medicare this exclusion will apply to that particular Part of Medicare for which you must pay only if you have enrolled in that Part.

If you have Medicare, your Medicare coverage will not affect the services covered under this Policy, except as follows:

1. Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and under this Policy.
2. If you receive a service that is covered both by Medicare and under this Policy, our coverage will apply only to the Medicare deductibles, coinsurance and other charges for Covered Services that you must pay over and above what's payable by your Medicare coverage.
3. For a particular claim, the combination of Medicare benefits and the benefits we will provide under this Policy for that claim will not be more than the Allowable Charge you have incurred for the Covered Services you received.

We will apply toward your Deductible any expenses paid by Medicare for services covered under this Policy, except for expenses paid under Medicare Part D.

The Policyholder who is Medicare disabled and/or 65 years of age or older may apply for an Anthem Nevada Plan which supplements Medicare benefits. **SERVICES, BENEFITS AND PREMIUMS UNDER A MEDICARE SUPPLEMENT PLAN WILL NOT BE THE SAME AS THOSE PROVIDED UNDER THIS POLICY.**

NONMEDICAL EXPENSES

NOT COVERED BEFORE YOUR EFFECTIVE DATE OR SERVICES RECEIVED AFTER YOUR COVERAGE ENDS

Services received before your Effective Date or received after your coverage ends.

NOT MEDICALLY NECESSARY

Any services or supplies that are:

- not Medically Necessary,
- not specifically described in this Policy, and
- part of a treatment plan for non-Covered Services or which are required to treat medical conditions which are a direct and predictable complication or consequence of non-Covered Services.

ORTHOPEDIC SHOES

except when joined to braces or shoe inserts.

OTHER DENTAL SERVICES

Dentures, bridges, crowns, caps, clasps, habit appliances, partials or other dental prostheses, Dental Services, extractions of teeth or treatment to the teeth or gums, except as specifically stated for dental care under the benefit sections of this Policy. **Dental Implants** (materials implanted into or on bone or soft tissue) or any associated procedure as part of the implantation or removal of implants. **Orthodontic Services**, braces, and other orthodontic appliances, except as specifically provided or arranged by us under the section called Dental Services in the PART called WHAT IS COVERED.

OTHER VISION CARE AND CERTAIN EYE SURGERIES

Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, routine eye refractions, and certain eye surgeries or any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia), except as specifically stated under the Vision sections in the PARTS called BENEFITS SUMMARY and WHAT IS COVERED.

OUTDOOR TREATMENT PROGRAMS

OUTPATIENT DRUGS AND MEDICATIONS NOT FROM A PHARMACY

Any Drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated under the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.

OUTPATIENT SPEECH THERAPY

Except following surgery, injury, or non-congenital organic disease as specifically described in this Policy.

OVER THE COUNTER PRODUCTS

Items available without a prescription including bandages, thermometers, home test kits like pregnancy tests and HIV test kits.

PERSONAL COMFORT ITEMS

Items which are furnished primarily for your comfort or convenience. Air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for comfort, hygiene or beautification.

PRE-EXISTING CONDITIONS

For members age 19 or older, no payment will be made for services or supplies for the treatment of a Pre-existing Condition during a period of twelve (12) months following your Effective Date. However, we may apply creditable coverage to satisfy or partially satisfy the twelve (12) month period if the length of time between the ending date of your prior coverage and your Effective Date under this Policy did not exceed sixty-three (63) days only if such prior coverage was with an Anthem individual plan.

PRIVATE DUTY NURSING

Inpatient or outpatient services of a private duty nurse unless we determine in advance that such services are Medically Necessary or as specifically covered under the PART called WHAT IS COVERED.

ROUTINE PHYSICAL EXAMS

or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except when covered during Office Visits as described in the Office Visits section under the PART called BENEFITS SUMMARY.

SERVICES FOR SOMEONE OTHER THAN THE POLICYHOLDER

Any person other than the Policyholder, including but not limited to the Policyholder's dependents, such as spouse, domestic partner, legal ward, natural child, adopted child and/or newborn child.

SERVICES FOR WHICH YOU ARE NOT LEGALLY OBLIGATED TO PAY

or for which no charge would be made if you did not have a health plan or insurance coverage.

SERVICES FROM RELATIVES

Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.

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SEX CHANGE

Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.

SEXUAL DYSFUNCTION

Services or prescriptions for the treatment of sexual dysfunction or impotence.

SKILLED NURSING FACILITY CARE**TELEPHONE, FACSIMILE MACHINE OR WEB CONSULTATIONS****TRANSPORTATION**

Commercial transport (air or ground), private aviation, or air taxi services, transportation by private automobile commercial or public transportation or wheelchair ambulance. Ambulance transport if the Policyholder could have been transported by automobile, commercial or public transportation without endangering their health or safety.

UNLISTED SERVICES

Services not specifically listed in this Policy as Covered Services.

WEIGHT REDUCTION

Services primarily for weight reduction or treatment of obesity or any care which involves weight reduction as the main method of treatment including bariatric surgery.

WORKERS' COMPENSATION

Any condition for which benefits are recovered or can be recovered either by any workers' compensation law or similar law even if you do not claim those benefits except for corporate officers who may opt out of Workers' Compensation coverage. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to Workers' Compensation law or similar law, we will provide the benefits of this plan subject to a conditional claims payment during an appeal process if a reimbursement agreement is signed.

PART 7 YOUR GENERIC PRESCRIPTION DRUG BENEFITS

We will provide outpatient Generic Prescription Drug benefits as explained in this PART, subject to all other terms, conditions, limitations and exclusions of this Policy. For the meaning of a term, which appears with the first letter of each word in capital letters, look at the Prescription Drug Definitions section at end of this PART.

Anthem uses a preferred list of Drugs, sometimes called a Formulary, to help your doctor make prescribing decisions. Your Prescription Drug benefits cover only Generic Prescription Drugs listed in the Anthem Generic Prescription Drug List/Formulary. This list of Drugs is updated quarterly by a committee consisting of doctors and pharmacists so that the list includes Generic Drugs that are safe and effective in the treatment of disease.

If you have a question regarding whether a Generic Drug is listed on the Anthem Generic Prescription Drug List/Formulary, please call customer service toll free at the phone number listed on your ID card.

For your convenience, the Anthem Generic Prescription Drug List/Formulary can be accessed online at **www.anthemprescription.com** or if you would like a copy of the Formulary, please contact us at The phone number listed on your ID card.

For an explanation of your Generic Prescription Drug coverage when you are enrolled in Medicare Part D, see the section called Non-Duplication of Medicare under the PART called WHAT IS NOT COVERED.

WHEN YOU GO TO A PARTICIPATING PHARMACY

When you present your identification card at a Participating Pharmacy, you will have the following Copayment/Coinsurance for each covered Prescription and/or refill listed on the Anthem Generic Prescription Drug List/Formulary:

- **Generic Drugs, insulin and metabolic foods:** \$10 Copayment for each Prescription and refill for up to a maximum 34-day supply.
- **Self-Administered Injectable Drugs:** 30% of the Contracted Amount for Self-Administered Injectable Drugs listed on the Anthem Generic Prescription Drug List/Formulary, except for insulin.

WHEN YOU ORDER BY MAIL

Your mail service Prescription Drug program is administered by Anthem Prescription Management. Your mail service Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Maintenance Drugs, an ongoing Generic Prescription listed on the Anthem Generic Prescription Drug List/Formulary, can be purchased by mail, requiring the following Copayment to be submitted for each Prescription:

- **Generic Drugs:** You pay a \$10 Copayment for each Prescription and/or refill for each 34-day supply or a \$20 Copayment for up to a maximum 90-day supply.

The Prescription must state the dosage and your name and address, and it must be signed by your Physician.

The first mail service Generic Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any of your subsequent mail service Prescriptions need only the Prescription and Copayment to be enclosed. You must authorize the pharmacist to release to the mail service Prescription Drug program information needed in connection with the filling of a Prescription.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail service Prescription Drug program including, but not limited to, antibiotics, Drugs that are not listed on

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the Anthem Generic Prescription Drug List/Formulary, and injectables, including Self-Administered Injectables except insulin. Please check with the customer service department at (800) 962-8192 for availability of the Drug or medication.

WHEN YOU GO TO A NON-PARTICIPATING PHARMACY

If you do not present your ID card at a Participating Pharmacy or receive services from a Non-Participating Pharmacy, you will have to pay the full cost of the Prescription. You should ask the pharmacist for an itemized receipt and submit it to Anthem with a written request for reimbursement. You will be reimbursed based on the Maximum Benefit Allowance for the covered drug, less the Copayment and Coinsurance listed in the Part called BENEFITS SUMMARY. Prescription Drugs that are not listed on the Anthem Generic Prescription Drug List/Formulary are not covered. Prescription drugs dispensed in excess of a 34-day supply of medication are not reimbursable.

CLAIMS AND CUSTOMER SERVICE

For **retail or mail service Pharmacy** information, please write to:

Anthem Prescription Management
Attn: Anthem Prescription Drug Program
P.O. Box 746000
Cincinnati, OH 45274-6000

For questions about **retail Prescription drug benefits**, call the toll free customer service phone number at (800) 317-9818.

For questions about the **mail service Prescription Drug program**, call the toll free customer service phone number at (800) 962-8192 or check the web site at www.anthemprescription.com.

WHAT IS COVERED

If listed on the Anthem Generic Prescription Drug List/Formulary, the following Generic Prescription Drugs are covered under this PART.

- Outpatient Generic Drugs and medications which federal and/or state of Nevada law restrict to sale by Prescription only.
- Insulin and insulin syringes prescribed and dispensed for use with insulin. Lancets and test strips for use in monitoring diabetes.
- All non-infused compound Generic Prescriptions which contain at least one covered Prescription ingredient.
- Oral contraceptive Generic Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA-approved Prescription contraceptive method will be covered.
- Metabolic foods are covered for inherited enzymatic disorders described under the Food and Nutrition section in the PART called WHAT IS COVERED.

CONDITIONS OF SERVICE

The Drug or medicine must:

- Be a Generic form of the Prescription and listed on the Anthem Generic Prescription Drug List/Formulary.
- Be prescribed in writing by a Physician and be dispensed within one (1) year of being prescribed, subject to federal or state laws.
- Be approved for use by the Food and Drug Administration (FDA).
- Be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or Drugs for cosmetic purposes are not included.
- Be purchased from a licensed retail Pharmacy, dispensed by a Physician or ordered by mail through the mail service Prescription Drug program.
- Not be used while you are an inpatient in any Facility.

Note: We will provide Prescription Drug benefits for up to a 34-day supply for each 31-day period (unless ordered by mail through the mail service Prescription Drug program, in which case the limit is a 90-day supply).

DRUG UTILIZATION REVIEW

Your Prescription Drug benefits include utilization review of Generic Prescription Drug usage for your health and safety. Certain Generic Drugs may require prior authorization. This prior authorization is done by the Participating Pharmacy who can call us at (800) 317-9818 to obtain approval. A Participating Pharmacist can help arrange to dispense an emergency amount of a covered Generic Prescription Drug. If there are patterns of over utilization or misuse of Drugs, we will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

WHAT IS NOT COVERED UNDER YOUR PRESCRIPTION DRUG BENEFITS

IN ADDITION TO LIMITATIONS ON PRE-EXISTING CONDITIONS OR ANY OTHER EXCLUSIONS OR LIMITATIONS CONTAINED IN THIS ENTIRE POLICY, PRESCRIPTION DRUGS AND REIMBURSEMENT WILL NOT BE FURNISHED FOR:

- Prescription Drugs that are not listed on the Anthem Generic Prescription Drug List/Formulary.
- Brand Name Drugs, except as listed on the Anthem Generic Prescription Drug List/Formulary.
- Drugs or medications which may be obtained without a Physician's Prescription, except insulin and niacin for cholesterol lowering.
- All Prescription and non-Prescription herbs, botanicals and nutritional supplements which have not been approved by the Food and Drug Administration (FDA) to diagnose, treat, cure or prevent a disease.
- Non-medicinal substances or items **including** pharmaceuticals to aid smoking cessation (e.g., Nicorette) or any Prescription product containing nicotine. However, please see available benefits described in the Programs to Stop Tobacco Use section under the PART called BENEFITS SUMMARY.
- Dietary supplements, vitamins, cosmetics, health or beauty aids or similar products which have not been approved by the Food and Drug Administration (FDA) to diagnose, treat, cure or prevent a medical condition.
- Drugs taken while you are in a Hospital, skilled nursing facility, rest home, sanatorium, convalescent Hospital or similar Facility.
- Any expense incurred in excess of Anthem's Contracted Amount at a Participating Pharmacy.
- Any drug labeled "Caution, limited by federal law to investigational use" or non-FDA approved investigational drugs. Any drug or medication prescribed for experimental indications, for example, progesterone suppositories.
- Syringes and/or needles except those dispensed for use with insulin.
- Durable Medical Equipment, devices, appliances, and supplies except lancets and test strips for use in the monitoring of diabetes.
- Immunizing agents, biological sera, blood, blood products or blood plasma. Oxygen.
- Professional charges in connection with administering, injecting or dispensing Drugs. Infusion medications.
- Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities, doctors' offices and home IV therapy.
- Drugs used for cosmetic purposes, for example, Retin-A for wrinkles and Rogaine for hair growth.
- Drugs and medications used for pregnancy, maternity care or abortion. However, oral contraceptives are covered as specifically stated in the section called What Is Covered under this PART.
- Drugs used for the primary purpose of treating Infertility.
- Drugs used for weight loss except when Medically Necessary.
- Drugs obtained outside the United States.
- Allergy desensitization products, allergy serum.
- All Infusion Therapy is excluded under this Policy except where specifically stated under the PARTS called BENEFITS SUMMARY and WHAT IS COVERED.
- A Prescription dispensed in excess of a 34-day supply (unless ordered by mail through the mail service Prescription Drug program, in which case the limit is a 90-day supply).
- Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent.

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PRESCRIPTION DRUG DEFINITIONS

Brand Name Prescription Drug (Brand Name) is a Prescription Drug that has been patented.

Drugs mean Prescription Drugs approved by the state of Nevada or the Food and Drug Administration (FDA) for general use by the public. For purposes of this benefit, insulin will be deemed a Prescription Drug.

Formulary (Anthem Generic Prescription Drug List/Formulary) is a list of Drugs which Anthem has determined to be safe and cost-effective based on available medical literature. This Formulary is used by Anthem.

Generic Prescription Drug (Generic) is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Maintenance Prescription Drugs are Prescription Drugs that are taken for an extended period of time to treat a medical condition.

Non-Participating Pharmacy is a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. You will have to pay the full cost of the prescription and submit it to Anthem with a written request for reimbursement.

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. To identify a Participating Pharmacy, call your local Pharmacy directly or call customer service toll free at (800) 317-9818. Some Participating Pharmacies display an Anthem "Rx" decal so that you can easily identify them.

Pharmacy means a licensed retail Pharmacy.

Prescription means a written order issued by a Physician.

Self-Administered Injectable Drugs are injectable Drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member.

PART 8 WHEN YOU TRAVEL OUTSIDE NEVADA

If you plan to travel outside Nevada, it might be a good idea to know your medical and Prescription Drug benefits in advance. The information in this PART describes how the BlueCard Program works and the types of Providers you may encounter outside Nevada. If you want to know about your payment responsibility for Covered Services that you receive outside Nevada, look at the BlueCard Program section in the PART called BENEFITS SUMMARY. Also, your Generic Prescription Drug benefits are described in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS. All provisions for this Policy are used to determine whether services are covered when you use the BlueCard Program except for vision services.

BLUECARD PROGRAM FOR MEDICAL SERVICES RECEIVED OUTSIDE NEVADA

When a member obtains health care services through BlueCard® outside the geographic area Anthem serves (Nevada), the amount the member pays for Covered Services is calculated on the **lower** of:

- The billed charges for the Covered Services, or
- The Negotiated Price that the on-site Blue Cross and/or Blue Shield Plan (“Host Blue”) passes on to Anthem.

Often, this “Negotiated Price” will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements, and non-claims transactions with the member’s health care provider or with a specified group of providers. The Negotiated Price may also be billed charges reduced to reflect an **average** expected savings with the member’s health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The Negotiated Price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount the member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard® method noted above or require a surcharge, Anthem will then calculate the member’s liability for any Covered Services in accordance with the applicable state statute in effect at the time the member received care.

BLUECARD PROVIDER TYPES

PPO Providers

These are primarily Hospitals and Physicians who participate in a BlueCard PPO network and have agreed to provide you with health care services at a discounted rate that is generally lower than the rate charged by Traditional Providers.

Traditional Providers

These are Providers who might not participate in a BlueCard PPO network but have agreed to provide you with health care services at a discounted rate.

Non-Participating Providers

These are Providers that do not have a contract with their local Blue Cross and/or Blue Shield plan and have not accepted the BlueCard or Traditional Provider negotiated rates.

To locate a BlueCard PPO or Traditional Provider when outside of Nevada visit the BlueCard web site address: www.bluecares.com/bluecard or call **(800) 810-BLUE (2583)**.

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WHEN YOU TRAVEL OUTSIDE THE UNITED STATES

In an emergency or Urgent Care situation you should go to the nearest health care Facility. You will need to pay the bill in full. Use of a credit card is encouraged because the credit card company will automatically transfer the foreign currency into American dollars. When you return home, you should fill out a claim form, which is available by contacting our customer service department. You must submit the claim form along with the receipts to the listed address. The amount submitted must be in American dollars. We may require medical records of the services received. You are responsible for providing such medical records. It may be necessary for you to provide an English translation of the medical records.

BLUECARD ACCESS

When you are temporarily away from our service area (Nevada) and need Urgent or after-hours medical care, you can follow the steps outlined below:

- If a life or limb-threatening emergency, call 9-1-1 or go to the nearest medical Facility.
- To find the nearest Urgent Care Facility, you may call the BlueCard Program to find the name and addresses of nearby PPO doctors and Hospitals or Urgent Care Facility by calling the phone number listed on your ID card or by using the BlueCard doctor and Hospital finder website at www.BCBS.com.
- If you are unable to contact the BlueCard Program, you should go to the nearest medical Facility.
- The BlueCard Program will inform you whether there is a PPO Provider in the area. When you arrive at the PPO doctor's office, Hospital, or Urgent Care Facility, simply present your health benefit ID card.
- If you use a BlueCard Provider, you pay the appropriate payment. If you do not use a BlueCard PPO or Traditional Provider, you pay the entire cost of care and will need to submit a claim to Anthem. Anthem will then reimburse you for these Non-Participating Providers based on the Maximum Benefit Allowance, less applicable Copayment, Deductible, and/or Coinsurance.

PART 9 IMPORTANT INFORMATION ABOUT YOUR PLAN

BENEFITS NOT TRANSFERABLE

You are the only person entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN TERMINATION OR RESCISSION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

CONFORMITY OF THIS POLICY

Any provision of this Policy which, on or after its Effective Date, is in conflict with any applicable statute, regulations or other law is hereby amended to conform to the minimum requirements of such law.

CONTENT OF THIS POLICY

This Policy, including any endorsements or attached paper, individual enrollment application/change form, identification card and rate sheet are the entire contract of insurance. Its terms can be changed only by a written endorsement signed by one of our authorized officers. NO AGENT OR EMPLOYEE OF OURS IS AUTHORIZED TO CHANGE THE TERMS OR WAIVE ANY OF THE PROVISIONS OF THIS POLICY.

CONTINUITY OF CARE

In the event you are receiving medical treatment for a medical condition from a Provider whose contract for services with Anthem is terminated during the course of your medical treatment, you may continue to receive medical treatment for that medical condition from the Provider if:

- You are actively undergoing a Medically Necessary course of medical treatment; and
- You and the Provider agree that continuity of care is desirable.

You may receive continued care as described above until the later of:

- 120 days after the Provider's contract with Anthem was terminated: or
- If you are pregnant, 45 days after the date of delivery or if the pregnancy does not end in delivery, the date of the end of the pregnancy.

You may not receive continued care as described above if Anthem terminates the Provider's contract because of the medical incompetence or professional misconduct of the Provider if Anthem does not enter into another contract with such Provider.

CONTRACTING ENTITY

You hereby expressly acknowledge that you understand that the Policy constitutes a contract solely between you and Anthem, an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which is an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits Anthem to use the Blue Cross and Blue Shield Service Mark, and in doing so, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association. You further acknowledge and agree that you have not entered into the Policy based on representations by any person other than an Anthem representative, and that no person, entity or organization other than Anthem will be held accountable or liable to you for any of Anthem's obligations created under this Policy. This paragraph does not create any additional obligations whatsoever on Anthem's part other than those obligations created under other provisions of the Policy.

FRAUDULENT INSURANCE ACTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a

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Policyholder or claimant for the purpose of defrauding or attempting to defraud the Policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance within the Department of Business and Industry.

Insurance fraud results in cost increases for health care coverage. You can help decrease these costs by doing the following:

- Be wary of offers to waive Copayments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the explanation of benefits received from Anthem. If there are any discrepancies, call our customer service department.
- Be very cautious about giving your health insurance coverage information over the phone.

If fraud is suspected, you should contact Anthem's customer service department. Anthem reserves the right to recoup any benefit payments paid on your behalf if you have committed fraud or material misrepresentation in applying for coverage in or receiving or filing for benefits.

GOVERNING LAW

The laws of the state of Nevada will be used to interpret any part of this Policy.

LEGAL ACTIONS

Before a Policyholder takes legal action on a claim decision, the Policyholder must first follow the process outlined under the PART called IF YOU HAVE A COMPLAINT and the Policyholder must meet all the requirements of this Policy.

No action in law or in equity shall be brought to recover on this Policy prior to expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this Policy. No such action shall be brought at all unless brought within three years after claim has been filed as required by the Policy.

NOTICE REQUIREMENTS

We will meet any notice requirements by mailing the notice to you at the address listed in our records. You will meet any notice requirements by mailing the notice to:

Anthem Blue Cross and Blue Shield
P.O. Box 5728
Denver, CO 80217-5728

OBLIGATION TO SUPPLY INFORMATION AND COOPERATE

You must provide Anthem with any information Anthem considers necessary to determine whether, or to what extent, services are covered under this Policy, or to carry out the other provisions of this Policy.

You agree to cooperate at all times (including while hospitalized) by allowing Anthem access to your medical records to investigate claims and verify information provided in your Enrollment Application/Change Form and/or Health Statement.

If you do not supply information or cooperate as described above, Anthem may deny the claims subject to investigation and Anthem, where permitted by law, may terminate your coverage.

PAYMENT TO PROVIDERS (AND PROVIDER REIMBURSEMENT)

Covered Services for PPO, Participating and Non-Participating Providers are based on the Allowable Charge. PPO Providers have a Participating Provider Agreement and an additional agreement with us and have agreed to accept the Contracted Amount as payment in full. Participating Providers have a Participating

Provider Agreement in effect with us and have agreed to accept the Contracted Amount as payment in full. Non-Participating Providers do not have a Participating Agreement with Anthem Blue Cross and Blue Shield. Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use PPO or Participating Providers. You will be responsible for any balance of a Provider's bill that is above the Maximum Benefit Allowance payable under this Policy for Non-Participating Providers. Please read the benefit sections carefully to determine those differences. We pay the benefits of this Policy directly to Non-Participating Providers, when you have authorized assignment of benefits to them. We may require a copy of the assignment of benefits for our records. These payments fulfill our obligation to you for those services.

PHYSICAL EXAMINATION AND AUTOPSY

At our own expense, we have the right and opportunity to examine the Policyholder claiming benefits when and as often as it may reasonably be required during the pendency of a claim and also to have an autopsy done in the case of death where it is not otherwise prohibited by law.

RECEIPT OF INFORMATION

We are entitled to receive from any Provider of service information about you that is necessary to administer claims on your behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, you have authorized every Provider who has furnished or is furnishing care to disclose all facts, opinions or other information pertaining to your care, treatment and physical conditions, upon our request. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of your claims until the necessary information is received.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request. Contact us toll free at (800) 317-9818 for a copy.

REINSTATEMENT

If you fail to pay insurance premiums by the end of the time period granted by Anthem, it will result in termination of the Policy. You must reapply for a new policy and will be subject to Anthem's underwriting guidelines, and all applicable state and local laws, at the time of application.

Anthem will not reinstate Policies for which payment of all past due premium is not received by Anthem within the month following the grace period. Any amounts received after this date will be returned or refunded to the Policyholder.

RELATIONSHIP OF PARTIES

We have an independent contractor relationship with our PPO or Participating Providers; Physicians and other Providers who are not our agents or employees, and our employees are not employees or agents of any of our PPO or Participating Providers. We have no control over any diagnosis, treatment, care or other service provided to you by any Facility or Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any of our PPO or Participating Providers by reason of negligence or otherwise.

We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs and mental health behavioral health. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or customer service duties on our behalf.

Questions? Visit our web site **tonikhealth.com** or call customer service **1-800-317-9818**

RESPONSIBILITY TO PAY PROVIDERS

In accordance with Nevada law, you will not be required to pay any PPO or Participating Providers for amounts owed to that Provider by Anthem (not including Copayments, Deductibles and services or supplies that are not a benefit of this Policy), even in the unlikely event that Anthem fails to pay the Provider. You are liable, however, to pay Non-Participating Providers for any amounts not paid to them by Anthem.

RIGHT OF RECOVERY

When the amount paid by us exceeds the amount for which we are liable under this Policy, we have the right to recover the excess amount from you unless prohibited by law.

TERMS OF COVERAGE

- In order for you to be entitled to benefits under this Policy, your coverage under this Policy must be in effect on the date you receive the service or supply except as specifically provided in the PART called WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE. Under this Policy, an expense is incurred on the date you receive a service or supply for which the charge is made.
- This Policy, including all terms, benefits, conditions, limitations and exclusions, may be changed by us as provided in the PART called WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE.
- The benefit to which you may be entitled will depend on the terms of coverage as set out in the Policy in effect on the date you receive the service or supply.

TIME LIMIT ON CERTAIN DEFENSES

After three years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the Policyholder in the application for such Policy will be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such three-year period.

The foregoing Policy provision shall not be so construed to affect any legal requirement for avoidance of a policy or denial of a claim during such initial three-year period, nor to limit the application of information in this provision in the event of misstatement with respect to age or occupation or other insurance.

After this Policy has been in force for a period of three years during the lifetime of the Policyholder (excluding any period during which the Policyholder is disabled), it shall become incontestable as to the statements contained in the individual enrollment application.

No claim for loss incurred or disability, as defined in the Policy, commencing after one year from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss existed prior to the Effective Date of coverage of this Policy.

An individual health benefit coverage shall not define a Pre-Existing Condition more restrictively than an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional or took Prescription drugs within the 6 months immediately preceding the Effective Date of coverage.

TIME OF PAYMENT OF CLAIM

Any benefits due under this Policy shall be due once we receive proper written proof of loss together with any such additional information reasonably necessary to determine our obligation.

WORKERS' COMPENSATION INSURANCE

This Policy does not take the place of, or affect any requirement for or coverage by, workers' compensation insurance.

PART 10 IF YOU HAVE A COMPLAINT

COMPLAINTS

If you have a complaint about services from Anthem or your health care Provider, please call us toll free at (800) 317-9818 or write us at:

Anthem BCBS
P.O. Box 5747
Denver, CO 80217-5747

If you have questions regarding your eligibility or membership, please contact us toll free at (800) 317-9818 or write us at:

Anthem BCBS
P.O. Box 5728
Denver, CO 80217-5728

A trained representative will work to clear up any confusion and resolve the concerns. If you are not satisfied with the resolution of your concerns, you may file an appeal as explained in this PART under Appeals.

APPEALS

Your appeal must be submitted in writing. While Anthem encourages you to file appeals within 60 days of the adverse benefit determination, your written appeal must be received by Anthem within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. Anthem will assign a customer advocate to assist the Policyholder in the appeal process. You must send written appeals to the following address:

Anthem
Appeals Department
P.O. Box 10330
Reno, NV 89520-0030

An appeal may be filed with or without first submitting a complaint. In the appeal, you must state plainly the reason(s) why the claim or requested service or supply should not have been denied. You should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on our decision.

For a thorough, unbiased review, you may access two internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available to you. For pre-service denials based on utilization review, an expedited appeal and expedited independent external review may be available in certain circumstances.

You may designate a representative (e.g., your Physician or anyone else of your choosing) to file any level of appeal review with us on your behalf. You must give this designation to us in writing.

The Appeals process is governed by laws and regulations, and may be modified from time to time by Anthem as those laws may require. A more detailed description of the Appeals process and the decision timeframes is set forth in our appeals guide. This guide is available through our website or may be obtained free of charge by calling customer service.

Questions? Visit our web site tonikhealth.com or call customer service **1-800-317-9818**

GRIEVANCES

You may send a written grievance to the following address:

Anthem
Quality Management Department
700 Broadway MC0532
Denver, CO 80273

Receipt of your grievance will be acknowledged by Anthem's Quality Management Department and the grievance will be investigated by Anthem's Quality Management Department. Anthem treats each grievance investigation in a strictly confidential manner.

DIVISION OF INSURANCE

If you have a problem regarding your coverage, please contact Anthem first to resolve the issue. If contacts between you (the complainant) and Anthem Blue Cross and Blue Shield (the Insurer) have failed to produce a satisfactory solution to the problem, you may wish to contact the Division of Insurance. For inquiries about health care coverage in Nevada, please call the Division of Insurance within the Department of Business and Industry between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday and ask for the Division of Insurance. The toll free number is (800) 992-0900 and the local numbers are (775) 687-4270 in Carson City and (702) 486-4009 in Las Vegas.

Although the numbers above are designed to assist members with inquiries and complaints about health care coverage in Nevada, the Division of Insurance is not equipped to resolve customer service related inquiries. Please continue to refer these types of inquiries to Anthem's customer service department.

BINDING ARBITRATION

Any dispute between you and Anthem must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the small claims court, and not by lawsuit or resort to court process. Any such arbitration will be governed by the procedures and rules established by the American Arbitration Association. You may obtain a copy of the Rules of Arbitration by calling Anthem's customer service department. The law of the state in which the Policy was issued and delivered to the Policyholder shall govern the dispute. The decision in arbitration is binding upon both you and us. Judgment on the award given in arbitration may be enforced in any court that has proper jurisdiction. In the event any person subject to this arbitration clause initiates legal action of any kind, without first complying with this binding arbitration clause, Anthem may apply for a court of competent jurisdiction to enjoin, stay or dismiss any such action and direct the parties to arbitrate in accordance with this provision. The question of what disputes are subject to this arbitration clause shall be determined by the arbitrator. Anthem is not liable for punitive damages.

LEGAL ACTION

Before you take legal action, including without limitation an arbitration, on a claim decision, you must first follow the process outlined under Appeals in this PART and you must meet all the requirements of this Policy.

No action or arbitration, in law or in equity shall be brought to recover on this Policy prior to expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this Policy.

PART 11 NON-DUPLICATION OF ANTHEM BENEFITS

If, while covered under this individual Policy, you are also covered by another Anthem Blue Cross and Blue Shield individual Policy:

- you will be entitled only to the benefits of the Policy with the greater benefits, and
- we will refund any premiums received under the Policy with the lesser benefits, covering the time period both Policies were in effect. However, any claims payments made by us under the Policy with the lesser benefits will be deducted from any such refund of premiums.

PART 12 UTILIZATION MANAGEMENT AND PRESERVICE REVIEW PROCEDURES

IMPORTANT: Utilization Management and Preservice Review does not guarantee that you have coverage or that benefits will be paid, nor does it guarantee that amount of benefits to which you are entitled. The payment of benefits is subject to all terms, conditions, limitations and exclusions of this Policy. All Covered Services are subject to review by Anthem for Medical Necessity.

The review processes, which may be undertaken, are listed below in paragraphs named Preservice Review, Admission Review, Continued Stay Review and Retrospective Review.

Health care services may be provided in an inpatient or outpatient setting. Anthem covers care received in both locations provided the care you are receiving is appropriate to the setting and is Medically Necessary.

Inpatient care is provided in settings like a Hospital or wherever an overnight stay is part of your care, such as in an acute care facility (Hospital), rehabilitation facility, long-term care acute facility, sub-acute facility, rehabilitation facility or inpatient Hospice facility. Outpatient care is delivered in settings such as an ambulatory surgery center or your doctor's office, where there is no overnight stay.

Preservice Review is a process that Anthem uses to ensure you are being provided the right care in the most medically appropriate setting. The Preservice Review may set limits on the care to be given for which Anthem will pay for Covered Services.

Preservice Review

- All scheduled inpatient admissions require Preservice Review. This includes scheduled admissions for Severe Mental Illness, Alcohol and Drug Abuse and organ and tissue transplants.
- All unscheduled inpatient admissions require Preservice review. This includes unscheduled admissions for Severe Mental Illness, Alcohol and Drug Abuse and organ and tissue transplants. Anthem requires notification of an unscheduled (emergency) admission within one business day, or as soon as practical, after the admission.
- All scheduled outpatient services for Severe Mental Illness and Alcohol and Drug Abuse conditions, where the service is provided in a facility require Preservice Review, even if no overnight stay is expected.
- Diagnostic radiology procedures require Preservice Review.
- Other specific procedures as specified by Anthem. For a list of current procedures, you may go to Anthem's website at anthem.com or call Anthem's customer service department at (800) 317-9818.

You are always responsible for initiating Preservice Review by having your Physician obtain Preservice Review for all services requiring Preservice Review. To determine which outpatient services require Preservice Review, the Physician or Policyholder may go to Anthem's website at anthem.com or call Tonik's customer service department at (800) 317-9818 for a list of procedures and services that require Preservice Review.

Questions? Visit our web site tonikhealth.com or call customer service **1-800-317-9818**

Preservice Review can be initiated by having the Physician call us at (702) 228-1277 or (800) 336-7767 at least three (3) business days before the scheduled service. Remember that you are responsible to see that Preservice Review is done. Whenever Preservice Review is required but not obtained, you will be required to pay an additional amount which will be the lesser of a \$250 or 50% of the amount which we allow. **This additional amount of \$250 or 50% of the amount which we allow is in addition to any other payment requirements of this Policy and will not apply toward satisfying your calendar Year Deductible or out-of-pocket maximum.**

Upon receipt of a Preservice Review request, Anthem may require additional information to determine Medical Necessity. Anthem will send written confirmation of Anthem's decision to the Policyholder and Physician within two business days of Anthem's receipt of all necessary information. The Preservice Review will be valid only for a specific period of time and place. The Policyholder must obtain the requested service within the time allotted in the Preservice Review and at the place authorized. If the Preservice Review period expires, or if additional services are requested, the Physician must contact Anthem to request another Preservice Review.

You or your representative may appeal Anthem's Preservice Review decision by following the procedure outlined in the Part called IF YOU HAVE A COMPLAINT.

IMPORTANT: Preservice Review of a procedure or a Facility stay for medical necessity is not a guarantee that benefits will be paid. Failure to pay premiums, fraud or abuse or change in your membership status could cause a denial of payment. Payments are based on the terms of your coverage and are subject to all exclusions and limitations of your Anthem coverage.

Admission Review. Anthem will determine at the time of admission if the service is Medically Necessary in the event Preservice Review is not conducted.

Continued Stay Review. Anthem will also determine if a continued Hospital stay is Medically Necessary. The length of Hospital stays related to mastectomy will be determined by the treating Physician in consultation with the patient.

Retrospective Review. Anthem will determine if any service was Medically Necessary in the event that Preservice Review, Admission Review or Continued Stay Review was not performed.

For a copy of the Medical Necessity review process, please contact our customer service department at (800) 317-9818.

PART 13 SUBSTITUTION OF BENEFITS

Care management is used when illnesses or injuries are so complex that individualized coordination of care is helpful. Examples of such situations include the medical management of a transplant candidate or of a patient with a spinal cord injury. In cases like these, a care manager may work with you and/or your family to help coordinate and facilitate the administration of medical care. A care manager may also help organize a safe transition from Hospital to home care. The care management program is designed to identify patients who may benefit from care management as early as possible in their course of medical treatment. The care manager will assess, address, document and resolve issues pertinent to the case in a consistent and timely manner. Care management promotes quality outcomes.

Depending on the level of care management you may need, a care manager may be assigned to you. Anthem employs nurses and other medically trained staff with special training in the coordination of care in complex cases. You may or may not have direct contact with an Anthem care manager. This depends on the availability of a liaison at the facility where you are admitted. If a care manager is assigned, the care manager's telephone number is provided to you so that you may contact the care manager with any questions. An assigned care manager works with the Providers, you and/or your family to create a plan of care, implement that plan, monitor the use and effectiveness of services, and determine if you are receiving services in a timely manner and in the most appropriate setting. Anthem has discretion as to which Policyholders it offers care management. Anthem may not offer care management to all Policyholders with similar conditions.

Anthem's care management program is tailored to the individual. In certain extraordinary circumstances involving intensive care management, Anthem may, at its sole discretion, provide benefits for alternate care that are not listed as Covered Services. Anthem may also extend Covered Services beyond the contractual benefit limits of this coverage. Anthem will make these decisions on a case-by-case basis. A decision to provide extended benefits or approve alternate care in one case does not obligate Anthem to provide the same benefits again to you or to any other Policyholder. Anthem reserves the right, at any time, to alter or cease providing extended benefits or approving alternate care. In such cases, Anthem will notify you or your representative in writing.

Questions? Visit our web site **tonikhealth.com** or call customer service **1-800-317-9818**

PART 14 IMPORTANT TERMS TO KNOW

Listed below are the definitions of important terms used in this Policy, which appear with the first letter of each word in capital letters. When you see these capitalized words, you should refer to these definitions, which are listed in alphabetical order. Please note, some terms may be defined within a specific benefit description or PART.

Accidental Injury is physical harm or disability which is the result of a specific, unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except infection of a cut or wound.

Allowable Charge for PPO Providers and Participating Providers, the Allowable Charge is the Contracted Amount. For Non-Participating Providers, the Allowable Charge is the amount billed or the Maximum Benefit Allowance, whichever is less.

Ambulatory Surgical Center is a freestanding outpatient surgical Facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must be licensed or certified or licensed by the State of Nevada.

Anthem Blue Cross and Blue Shield is Rocky Mountain Hospital and Medical Service, Inc., a Nevada insurance company doing business as Anthem Blue Cross and Blue Shield. Also referred to as "Anthem."

Attained Age is your age at the time of each of your premium billings. Your premiums are based upon your Attained Age. We will recalculate your age for each billing, and your premiums will be adjusted accordingly.

Authorized Referral occurs when you, because of your medical needs, require the services of a specialist who is a Non-Participating Provider or requires special services or facilities not available at a PPO or Participating Hospital but only when:

- there is no PPO or Participating Provider who practices in the appropriate specialty or there is no Participating Hospital which provides the required services or has the necessary facilities based on Anthem's network adequacy standards, and
- you are referred to the Non-Participating Hospital or Non-Participating Physician by a PPO Physician, and
- the referral has been authorized by Anthem before services are rendered.

Authorized Referrals are not available for services described under Organ and Tissue Transplants in the PART called WHAT IS COVERED.

BlueCard Program allows you to take advantage of discounts available through Blue Cross and Blue Shield policies for Covered Services rendered in other states. Discounts may be available through Blue Cross and Blue Shield policies for Covered Services in other countries only when emergency treatment is required.

Coinsurance is the percentage amount you are responsible for as stated in the PARTS called BENEFITS SUMMARY and WHAT IS COVERED. **Coinsurance does not include charges for services which are not covered or charges in excess of the amount we will allow for payment. These charges are your responsibility and are not included in the Coinsurance calculation.**

Congenital Defect is a defect or anomaly existing before birth, such as cleft lip or club foot. Disorders of growth and development over time are not considered congenital.

Contracted Amount is the amount paid to PPO Providers and Participating Providers who have a Provider contract with Anthem at the time services are rendered. PPO Providers and Participating Providers agree to accept the Contracted Amount as payment in full for a Covered Service. You will not be responsible for any

amount billed in excess of the Contracted Amount. However, you are still responsible for the payment of any applicable Deductible, Copayment or Coinsurance. You are always responsible for services or supplies not covered under this Policy. Cost sharing amounts are based on the Contracted Amount and are the amounts you pay to a PPO Provider or Participating Provider.

Copayment is the amount due and payable by you to the Provider of care.

Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Covered Services are Medically Necessary services or supplies which are listed in the benefit sections of this Policy and for which you are entitled to receive benefits.

Custodial Care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of a medical professional.

Day Treatment Program is an outpatient Hospital based program that is licensed according to state and local laws to provide outpatient care and treatment of a Mental Health Condition under the supervision of psychiatrists.

Deductible means the amount of charges you must pay in a calendar Year for any Covered Services before certain benefits are available to you under this Policy. Your Deductible is explained in the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE.

Dental Services are diagnostic, preventive or corrective procedures to treat on or to the teeth or gums, no matter why the services are provided and whether in treatment of a medical, dental or any other type of condition. **Dental Prostheses** are dentures, crowns, caps, bridges, clasps, habit appliances, partials, braces and orthodontic appliances.

Diabetes Equipment and Supplies means the following items for the treatment of insulin using diabetes or non-insulin using diabetes and gestational diabetes as Medically Necessary or medically appropriate:

- blood glucose monitors
- blood glucose testing strips
- blood glucose monitors designed to assist the visually impaired
- insulin pumps and related necessary supplies
- ketone urine testing strips
- lancets and lancet puncture devices
- pen delivery systems for the administration of insulin
- podiatric devices to prevent or treat diabetes related complications
- insulin syringes
- visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

Diabetes Outpatient Self-Management Training Program includes training provided to you after the initial diagnosis of diabetes in the care and management of that condition. This includes nutritional counseling and proper use of Diabetes Equipment and Supplies, additional training if a significant change in your symptoms or condition that requires changes in your self-management regime and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or Provider who is licensed, registered or certified in Nevada to provide appropriate health care services.

Questions? Visit our web site tonikhealth.com or call customer service **1-800-317-9818**

Effective Date is the date on which your coverage under this Policy begins. It appears on your Anthem identification card.

Emergency medical condition (Emergency) - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency services (Emergency care) means, with respect to an emergency medical condition:

1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

Experimental/Investigational Procedures are:

(a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which Anthem determines in its sole discretion to be Experimental or Investigational.

Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be Experimental or Investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

(b) Any service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Anthem. In determining whether a service is Experimental or Investigational, Anthem will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes.
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives.
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information Anthem considers or evaluates to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal.
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies.
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- Documents of an IRB or other similar body performing substantially the same function.
- Consent documentation(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- Medical records.
- The opinions of consulting Providers and other experts in the field.

(d) Anthem has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational.

Home Health Agencies are home health care Providers which are licensed according to state and local laws to provide skilled nursing care and other services on a visiting basis in your home or they must be approved as home health care Providers who are certified or licensed by the State of Nevada.

Hospices are Providers that are licensed according to state and local laws to provide skilled nursing care and other services to support and care for persons experiencing the final phases of terminal illness. They must be approved as Hospice Providers who are certified or licensed by the State of Nevada.

Hospital is a Facility which provides diagnosis, treatment and care of the Policyholder who needs acute inpatient Hospital care under the supervision of Physicians. It must be licensed or certified or licensed by the State of Nevada.

For the purpose of this Policy, the term acute psychiatric Facility also includes a psychiatric health Facility which is an acute 24-hour Facility as defined by Nevada law. It must be:

- licensed by the Nevada Department of Health Services,
- qualified to provide short-term inpatient treatment according to state law,
- licensed or certified by the State of Nevada,
- staffed by an organized medical or professional staff which includes a Physician as medical director, and
- actually providing an acute level of care.

Infertility means the presence of a demonstrated condition recognized by a licensed medical Physician as a cause of Infertility or the inability to conceive or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Infusion Therapy is the administration of Drugs (Prescription substances) by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin) and intrathecal (into the spinal canal) routes. For the purpose of this Policy, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

In-Network is the term for Providers that have entered into a PPO network agreement with us.

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Intractable Pain is a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system or organ of the body perceived as the source of the pain.

Maximum Benefit Allowance is the maximum dollar amount determined and approved by us which we pay to Non-Participating Providers for Covered Services and procedures. Our determination of a Maximum Benefit Allowance is the maximum amount we approve for any particular service. Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use a PPO Provider or a Participating Provider. Since the Non-Participating Provider has not agreed to accept the Maximum Benefit Allowance as payment in full, the amount billed by the Non-Participating Provider may exceed the Maximum Benefit Allowance. You will need to pay that excess amount, in addition to any applicable Deductible, Copayment or Coinsurance. Cost sharing amounts are based on the Maximum Benefit Allowance and are amounts you pay to a Non-Participating Provider.

Medical Equipment means medical equipment that generally can withstand repeated use and must serve a medical purpose.

Medically Necessary an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a Physician and/or licensed, certified or registered Provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the Policyholder and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention (“cost effective” does not mean lowest cost).
- Not Experimental/Investigational.
- Not primarily for the convenience of the Policyholder, the Policyholder’s family or the Provider.
- Not otherwise subject to an exclusion under this Policy.

The fact that a Physician and/or Provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

Medical Supplies means disposable items (except Prescription Drugs) which are required for the treatment of an illness or injury.

Negotiated Price (out-of-state Providers) often consists of a simple discount which reflects the actual price paid by the on-site Blue Cross/Blue Shield Licensee/Plan. However sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or specified group of Providers. The Negotiated Price may also be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The Negotiated Price will also be adjusted in the future to correct for over -or underestimation of past prices. However, the amount you pay is considered a final price.

Non-Participating Provider is a Provider which does **not** have a PPO or Participating Provider Agreement with Anthem in effect at the time services are rendered. Remember that benefits for Non-Participating Providers may result in a greater out-of-pocket expense to you except in the case of an Authorized Referral

as defined in this same PART. You will be responsible for any billed charges over the amount allowed under this Policy.

Office Visit is when you go to a Physician's office and have one or more of the following three services provided:

- History (gathering of information on an illness or injury)
- Examination
- Medical Decision Making (the Physician's actual diagnosis and treatment plan)

In addition, as explained in the PART called BENEFITS SUMMARY, other Covered Services (e.g., preventive care, routine physical exam, Urgent Care in the Physicians office or Urgent Care Facility services, surgery, diagnostic X-ray, laboratory, pathology and radiology) that you receive in your Physician's office during an Office Visit are covered under the Office Visit benefit. These other Covered Services are limited to treatment that can be appropriately performed in an Office Visit setting.

Out-of-Network is a term used for Providers who have not entered into a PPO agreement with Anthem, you pay a higher out-of-pocket expense for services provided by Out-of-Network Providers.

Participating Provider is a Provider which has a Participating Provider Agreement in effect with us and has negotiated certain charges as the Contracted Amount they will charge you for Covered Services under this Policy. The exception would be when Preservice Review is not obtained.

A directory of PPO and Participating Providers is available upon request through our customer service representatives.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than Drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise and radiation.

Policy is the set of benefits, conditions, exclusions and limitations described in this document.

Policyholder is the person (member) whose individual enrollment application has been accepted by us for coverage under this Policy.

PPO Provider is a Participating Facility Provider or a Participating Professional Provider that has entered into an additional agreement with Anthem, to limit charges for services performed under this Policy.

Pre-existing Condition means an illness, injury, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of Prescription Drugs was recommended or received from a licensed health care Provider during the six (6) months immediately preceding your Effective Date of coverage.

For members age 19 and older, Anthem will not pay for services related to a pre-existing condition for twelve consecutive months after the member's effective date of membership, unless the member had continuous prior coverage and no lapse in coverage of more than 63 days prior to enrollment. The member will receive credit against the twelve-month preexisting condition limitation period for each day of prior coverage. The member may contact Anthem's Customer Service department for additional information on how this may apply to the member.

Provider means a person or Facility recognized by Anthem as a health care Provider and that fits one or more of the following descriptions:

- **Professional Provider** there are two types of Professional Providers:
 - **Physician** means a doctor of medicine or osteopathy who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

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- **Professional Provider** is a Physician or other Professional Provider who is licensed or otherwise authorized by the state or jurisdiction where services are provided to perform designated health care services. For benefits to be payable, services of a Professional Provider must be within the scope of the authority granted by the license and covered by this Policy. Such services are subject to review by a medical authority appointed by Anthem. Other Professional Providers include, among others, certified nurse midwives, dentists, optometrists and certified registered nurse anesthetists. Services of such a Provider must be among those covered by this Policy and are subject to review by a medical authority appointed by Anthem.
- **Facility Provider** there are two types of Facility Providers, inpatient and outpatient:
 - **Inpatient Facility Provider** means a Hospital, Hospice Facility, or other Facility that Anthem recognizes as a health care Provider.
 - **Outpatient Facility Provider** means an ambulatory surgery center, dialysis center, Veteran's Administration or Department of Defense Facility, Home Health Agency or other Facility Provider (except a Hospital or Hospice Facility) recognized by Anthem and licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a Provider must be among those covered by this Policy and are subject to review by a medical authority appointed by us.

Reconstructive Surgery is surgery that is Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by Congenital Defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance, to the extent possible.

Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Resident is an individual who maintains legal domicile within the state of Nevada and is presumed, for purposes of this agreement, to be a primary Resident of the state, as evidenced by any three of the following:

- Payment of Nevada income tax
- Employment in Nevada, other than that normally provided on a temporary basis to students
- Ownership of residential real estate property in Nevada
- State identification card or driver's license
- Acceptance of future employment in the state of Nevada
- Vehicle registered in Nevada
- Voter registration in Nevada
- Phone bill or utility bill from Nevada

Stabilize means, with respect to an emergency medical condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Severe Mental Illness is schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

Urgent Care is provided for individuals who require immediate medical attention but whose condition is not life-threatening (non-emergency).

Year (Yearly) is a twelve (12) month period starting each January 1 at 12:01 a.m. Pacific Standard Time.

WELLNESS AND HEALTH EDUCATION

At Anthem Blue Cross and Blue Shield we believe it is important for you to have control of your health care. Anthem has available for you, from time to time, various resources to help you learn more about good health habits.

The following programs are currently provided by Anthem as a service to you; these services do not constitute benefits under this Policy and are subject to change or withdrawal without notice.

Disease management is used to help coordinate care for Policyholders who have been diagnosed with specific, persistent or chronic conditions. Anthem may offer disease management programs to Policyholders with high-risk pregnancies or who have been diagnosed with chronic illnesses, such as diabetes, heart disease and asthma.

Disease management strategy includes working with you to promote self-management and encouraging compliance with the plan of care developed by your Provider. Disease management emphasizes disease prevention, education and coordination of care to avoid acute episodes and/or gradual worsening of the disease over time. Anthem's disease management programs are based on the best evidence and practices available in peer-reviewed medical literature. Reports are regularly communicated to your Provider to promote continuity of care.

Anthem may not offer disease management programs to all Policyholders who have conditions such as those mentioned above. A decision to offer a disease management program to a Policyholder does not obligate Anthem to offer other programs to that person or to offer that program to other Policyholders.

Participation in disease management programs is voluntary, and you may choose whether to participate at any time. More complicated conditions may require more intense and/or frequent services.

The PPO or Participating Provider agreement of providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referral to other Providers, including In-Network Providers and disease management programs. You may contact the Provider or Anthem for questions regarding such incentives or risk sharing relationships.

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Anthem Individual TONIK \$5,000 (DN12, 061N)

Effective 09-2010

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| DEDUCTIBLE | \$5,000 per calendar Year | <p>Amounts paid for the first four (4) Office Visits in a calendar Year, emergency room services, ambulance services, vision benefits (up to Anthem's maximum \$50 payment) and preventive care services are not subject to your Deductible.</p> <p>Please see the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE for more information.</p> |
| OUT-OF-POCKET MAXIMUM | \$5,000 per calendar Year | <p>Amounts paid for certain services will not be applied to your out-of-pocket maximum, including the first four (4) Office Visits in a calendar Year, emergency room services, ambulance services, vision care, preventive care services, and the additional amount for not obtaining Preservice Review.</p> <p>Amounts paid for services received from Non-Participating Providers for physical therapy, occupational therapy and/or chiropractic care will not be applied to your out-of-pocket maximum.</p> <p>Please check the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE for more information.</p> |
| | \$10,000 per calendar Year | |

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| <p>OFFICE VISITS</p> | <p>You pay a \$20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all charges up to the Contracted Amount.</p> <p>After your Deductible has been satisfied, you do not pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year.</p> | <p>You pay 30% of Contracted Amount per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all charges up to the Contracted Amount.</p> <p>After your Deductible has been satisfied, you pay 30% of Contracted Amount for the remainder of that calendar Year.</p> | <p>You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all billed charges.</p> <p>After your Deductible has been satisfied, you pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance for remainder of that calendar Year.</p> | <p>No Deductible is required for the first four (4) Office Visits (professional and preventive care Office Visits combined), PPO, Participating and Non-Participating Providers combined, per calendar Year.</p> <p>Covered Services, including routine physical exams, preventive care, Urgent Care in the Physician's office or Urgent Care Facility, and professional services that you receive in your Physician's office during the Office Visit, are covered under this benefit.</p> <p>Copayments and Coinsurance paid for the first four (4) Office Visits in a calendar Year will not be applied to the Deductible or out-of-pocket maximum.</p> |
| <p>PROFESSIONAL SERVICES</p> | <p>You do not pay any Coinsurance.</p> | <p>You pay 30% of Contracted Amount.</p> | <p>You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance.</p> | <p>This benefit is separate from professional services covered under the Office Visit benefit (see above) and includes benefits for diagnostic X-ray and laboratory services which are not received during your Physician's Office Visit.</p> <p>Refer to the section Professional Services under the PART called WHAT IS COVERED for a detailed description of Covered Services under this benefit.</p> |

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| <p>EMERGENCY CARE IN AN EMERGENCY ROOM</p> | <p>You pay a \$100 Copayment for each emergency room visit.</p> <p>This Copayment covers the emergency room visit and Covered Services that you receive in the emergency room during that visit.</p> | <p>You pay a \$100 Copayment for each emergency room visit.</p> <p>This Copayment covers the emergency room visit and Covered Services that you receive in the emergency room during that visit.</p> | <p>You pay a \$100 Copayment for each emergency room visit.</p> <p>This Copayment covers the emergency room visit and Covered Services that you receive in the emergency room during that visit.</p> | <p>No Deductible is required.</p> <p>Your \$100 Copayment is waived if the emergency room visit results in an inpatient admission into a Hospital immediately following the emergency room services.</p> <p>Copayment amounts will not be applied to the Deductible or out-of-pocket maximum, and you will continue to be responsible for Copayment after your Deductible and out-of-pocket maximum have been satisfied.</p> |
| <p>INPATIENT HOSPITAL</p> | <p>You do not pay any Coinsurance.</p> | <p>You pay 30% of Contracted Amount.</p> | <p>You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance.</p> | <p>For Severe Mental Illness, please see this PART and the PART called WHAT IS COVERED for details.</p> |
| <p>OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER</p> | <p>You do not pay any Coinsurance.</p> | <p>You pay 30% of Contracted Amount.</p> | <p>You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance.</p> | <p>For Severe Mental Illness, please see this PART and the PART called WHAT IS COVERED for details.</p> |
| <p>VISION</p> | <p>You pay all charges except \$50 per calendar Year.</p> | | | <p>No Deductible is required. Amounts paid do not apply to the Deductible or out-of-pocket maximum.</p> <p>Covered Services received under this benefit are separate from Covered Services received under any other benefit described in this Policy. For a description of Covered Services, please see the Vision section in the PART called WHAT IS COVERED.</p> |

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| <p>PREVENTIVE CARE Preventive Care Services in this section shall meet requirements as determined by federal and state law. These services fall under four broad categories as shown below:</p> <ol style="list-style-type: none"> 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: <ul style="list-style-type: none"> • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. | <p>Many In-Network preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member. That means Anthem pays 100% of the Allowable Charge</p> | <p>Office Visits: You pay 30% of Contracted Amount per Office Visit.</p> <p>For subsequent Office Visits, you pay all charges up to the Contracted Amount.</p> <p>After your Deductible has been satisfied, you pay 30% of Contracted Amount for the remainder of that calendar Year.</p> <p>Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you pay 30% of Contracted Amount.</p> | <p>Office Visits: You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance per Office Visit.</p> <p>For subsequent Office Visits, you pay all billed charges.</p> <p>After your Deductible has been satisfied, you pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance for the remainder of that calendar Year.</p> <p>Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance.</p> | <p>For services received from Out-of-Network providers, no Deductible is required for Office Visits (professional and Preventive Services Office Visits combined), for Participating and Non-Participating Providers combined, per calendar Year.</p> <p>Covered Services, including routine physical exams, preventive care and professional services that you receive in your Physician's office during the Office Visit are covered under this benefit.</p> <p>Copayments and Coinsurance paid to Out-of-Network providers for Office Visits in a calendar Year will not be applied to the Deductible or out-of-pocket maximum.</p> <p>See the PART called WHAT IS COVERED for a full description of covered preventive care services and preventive care services that are not subject to the Deductible.</p> |
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| <p>PREVENTIVE CARE (continued)</p> <p>2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;</p> <p>3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and</p> <p>4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration</p> | <p>Many In-Network preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member. That means Anthem pays 100% of the Allowable Charge</p> | <p>Office Visits: You pay 30% of Contracted Amount per Office Visit.</p> <p>For subsequent Office Visits, you pay all charges up to the Contracted Amount.</p> <p>After your Deductible has been satisfied, you pay 30% of Contracted Amount for the remainder of that calendar Year.</p> <p>Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you pay 30% of Contracted Amount.</p> | <p>Office Visits: You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance per Office Visit.</p> <p>For subsequent Office Visits, you pay all billed charges.</p> <p>After your Deductible has been satisfied, you pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance for the remainder of that calendar Year.</p> <p>Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance.</p> | <p>For services received from Out-of-Network providers, no Deductible is required for Office Visits (professional and Preventive Services Office Visits combined), for Participating and Non-Participating Providers combined, per calendar Year.</p> <p>Covered Services, including routine physical exams, preventive care and professional services that you receive in your Physician's office during the Office Visit are covered under this benefit.</p> <p>Copayments and Coinsurance paid to Out-of-Network providers for Office Visits in a calendar Year will not be applied to the Deductible or out-of-pocket maximum.</p> <p>See the PART called WHAT IS COVERED for a full description of covered preventive care services and preventive care services that are not subject to the Deductible.</p> |
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| <p>PHYSICAL THERAPY OCCUPATIONAL THERAPY AND/OR CHIROPRACTIC CARE</p> | <p>You do not pay any Coinsurance.</p> | <p>You pay 30% of Contracted Amount.</p> | <p>You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance.</p> | <p>Benefits are limited to 12 visits per calendar Year combined for Physical Therapy, Occupational Therapy and/or Chiropractic Therapy; PPO, Participating and Non-Participating Providers combined.</p> <p>Note: If Anthem determines that an additional period of Physical Therapy, Occupational Therapy and/or Chiropractic Care is both Medically Necessary and likely to result in a significant improvement to your condition during that period of additional care, Anthem will authorize a specific number of additional visits.</p> <p>Payments for Non-Participating Providers will not be applied to your out-of-pocket maximum, and you will continue to be required to pay these amounts even after your out-of-pocket maximum has been satisfied.</p> |
| <p>DENTAL SERVICES UNDER THIS POLICY</p> | <p>You do not pay any Coinsurance.</p> | <p>You pay 30% of Contracted Amount.</p> | <p>You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance.</p> | |
| <p>AMBULANCE</p> | <p>You pay \$100 Copayment per day for ground and/or air ambulance services.</p> | <p>You pay \$100 Copayment per day for ground and/or air ambulance services.</p> | <p>You pay \$100 Copayment per day for ground and/or air ambulance services.</p> | <p>No Deductible is required for ambulance services.</p> <p>Copayments amounts will not be applied to the Deductible or out-of-pocket maximum, and you will continue to be responsible for payment after your Deductible and out-of-pocket maximum have been satisfied.</p> |

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| SEVERE MENTAL ILLNESS | Benefits provided the same as for any other medical condition. | Benefits provided the same as for any other medical condition. | Benefits provided the same as for any other medical condition. | Anthem will cover benefits up to a maximum of 40 full inpatient days or 80 partial inpatient days per calendar Year; and 40 outpatient visits per calendar Year. Please see the PART called WHAT IS COVERED for details. |
| ALCOHOL AND DRUG ABUSE | Benefits provided the same as for any other medical condition. | Benefits provided the same as for any other medical condition. | Benefits provided the same as for any other medical condition. | |
| PROGRAMS TO STOP TOBACCO USE | Anthem will cover smoking cessation programs designed to end the dependence on nicotine as determined by federal and state law. Covered benefits apply to in network services only. Anthem pays 100% of the Allowable Charge. | Not covered | | |
| OTHER ELIGIBLE PROVIDERS Such as: Blood Bank Dentist (D.D.S.) Dispensing Optician Respiratory Therapist (except as provided for under Home Health Care) | You pay all charges in excess of the Maximum Benefit Allowance. | | | These Providers do not enter into Participating agreements with us, and they must be licensed according to state and local laws to provide Covered Services. Covered Services received from a dispensing optician under this benefit are separate from Covered Services received from a dispensing optician under the "Vision" benefit. |

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| MEDICAL SUPPLIES MEDICAL EQUIPMENT AND FOOTWEAR | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | Footwear is limited to a maximum Anthem payment of \$400 per calendar Year; PPO, Participating and Non-Participating Providers combined. For more information see the section Medical Supplies and Medical Equipment under the PART called WHAT IS COVERED. |
| FOREIGN COUNTRY PROVIDERS | For initial treatment of a Medical Emergency only. You pay a \$100 Copayment plus 30% after Deductible of billed charges for each emergency visit. | | | You are responsible, at your expense, for obtaining an English language translation of foreign country Provider claims and medical records. |
| HOME HEALTH CARE | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | Limited to 60 visits per calendar Year, up to 4 hours each visit; PPO, Participating and Non-Participating Providers combined. |
| INFUSION THERAPY | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | |
| HOSPICE | You do not pay any Coinsurance. | You pay 30% of Contracted Amount. | You pay 30% of Maximum Benefit Allowance plus all charges in excess of Maximum Benefit Allowance. | See Hospice under the PART called WHAT IS COVERED for additional information. |

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| <p>SPECIAL CIRCUMSTANCES FOR AUTHORIZED REFERRAL</p> | <p>This benefit does not apply to PPO Providers.</p> | <p>This benefit does not apply to Participating Providers.</p> | <p>You pay no more than what you would have paid if services had been received from a PPO or Participating Provider.</p> | <p>Non-Participating Providers: Professional Providers, Hospital (inpatient or outpatient), Ambulatory Surgical Center.</p> <p>Please see the PART called IMPORTANT TERMS TO KNOW for information about Authorized Referrals.</p> |
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| <p>ELECTIVE SERVICES OUTSIDE NEVADA BLUECARD PROGRAM</p> | <p>BlueCard PPO Provider: You do not pay any Coinsurance.</p> | <p>BlueCard Traditional Provider: You pay 30% of the BlueCard Provider's Negotiated Price.*</p> | <p>Non-Participating Provider: You pay 30% of the Maximum Benefit Allowance plus all charges in excess of the Maximum Benefit Allowance.</p> | <p>For emergency care see the information above under Emergency Care In An Emergency Room.</p> <p>For information about the BlueCard Program, including descriptions of the types of Providers you may encounter outside Nevada (i.e., PPO, Traditional and Non-Participating Providers), please see the PART called WHEN YOU TRAVEL OUTSIDE NEVADA.</p> <p>Please be advised that BlueCard PPO Providers are different than Anthem PPO Providers.</p> <p>*If there are no BlueCard PPO Providers where you are receiving care outside of Nevada, you do not pay any Coinsurance.</p> |
| <p>HOSPITAL OR AMBULATORY SURGICAL CENTER</p> | <p>BlueCard PPO Provider: You do not pay any Coinsurance.</p> | <p>BlueCard Traditional Provider: You pay 30% of the BlueCard Provider's Negotiated Price.*</p> | <p>Non-Participating Provider: You pay 30% of the Maximum Benefit Allowance plus all charges in excess of the Maximum Benefit Allowance.</p> | <p>For emergency care see the information above under Emergency Care In An Emergency Room.</p> <p>For information about the BlueCard Program, including descriptions of the types of Providers you may encounter outside Nevada (i.e., PPO, Traditional and Non-Participating Providers), please see the PART called WHEN YOU TRAVEL OUTSIDE NEVADA.</p> <p>Please be advised that BlueCard PPO Providers are different than Anthem PPO Providers.</p> <p>*If there are no BlueCard PPO Providers where you are receiving care outside of Nevada, you do not pay any Coinsurance.</p> |

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PART 6 WHAT IS NOT COVERED

We will not furnish benefits for the following services and supplies. They are considered to be exclusions and limitations, which include, but are not limited to the following:

ACUPUNCTURE AND ACUPRESSURE

ALTERNATIVE OR COMPLEMENTARY MEDICINES

Services in this category include holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique, clonics or iridology.

BIOFEEDBACK

BREAST REDUCTION

Breast reduction surgery (reduction mammoplasty) or services related to breast reduction surgery, unless the breast reduction surgery is performed because of breast cancer.

CLINICAL TRIALS

- Services for medical treatment received as part of a clinical trial or study described which are provided to you by the sponsor of the clinical trial or study free of charge to you.
- Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.
- Coverage for a drug or device which is paid for by the manufacturer, distributor or provider of the drug or device.
- Health care services that are specifically excluded from coverage under this coverage, regardless of whether such services are provided under the clinical trial or study.
- Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.
- Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that you may incur.
- Any expenses incurred by a person who accompanies you during the clinical trial or study.
- Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management.
- Any costs for the management of research relating to the clinical trial or study.

COMPLICATIONS OF NON-COVERED SERVICES

Complications arising from non-Covered Services and supplies. Examples of non-Covered Services include but are not limited to, Cosmetic Surgery, sex-change operations and procedures, which are determined to be Experimental/Investigational.

COSMETIC SURGERY

or other services that are performed to alter or reshape normal structures of the body in order to improve appearance.

CUSTODIAL CARE

or domiciliary or rest cures for which facilities and/or services of a general acute Hospital are not medically required. Custodial Care is care that does not require the regular services of trained medical or health professionals, such as but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets and supervision of medications which are ordinarily self-administered.

DIAGNOSTIC ADMISSIONS

Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

EDUCATIONAL SERVICES AND NUTRITIONAL COUNSELING

except as specifically covered or arranged by us under the Diabetes Outpatient Self-Management Training Program, provisions in the PART called WHAT IS COVERED.

EXCESS AMOUNTS

Any amounts in excess of the maximum amounts stated in the benefit sections of this Policy. Any amounts in excess of Allowable Charge except as provided herein.

EXPERIMENTAL OR INVESTIGATIONAL

Medical, surgical and/or other procedures, services, products, drugs or devices (including implants), which are Experimental and Investigational Procedures.

FOOD AND/OR DIETARY SUPPLEMENTS

except for formulas and special food products as specifically stated under Food and Nutrition in the PART called WHAT IS COVERED. They must be prescribed by a Physician and deemed Medically Necessary to prevent complications of PKU and other enzymatic disorders. Coverage is only to the extent that the prescribed formulas and special food products exceed the cost of a normal diet.

GENETIC TESTING OR COUNSELING

Preconception, paternity testing, court-ordered genetic counseling and testing, testing for inherited disorders, discussion of family history or testing to determine the sex or physical characteristics of an unborn child.

GOVERNMENT SERVICES

Any services provided by a local, state or federal government agency.

HEARING AIDS

Hearing aids and routine hearing tests unless specified by state or federal law.

INFERTILITY SERVICES

All services related to the evaluation or treatment of Infertility, including all tests, consultations, medications, surgical, medical or laboratory procedures.

INTRACTABLE PAIN OR CHRONIC PAIN

This coverage does not cover services or supplies for the treatment of Intractable Pain and/or chronic pain. Chronic pain is pain of continuous and long-standing duration where the cause cannot be removed.

LEARNING OR BEHAVIORAL THERAPIES**MATERNITY/PREGNANCY CARE**

No benefits are covered for pregnancy, maternity care or elective or therapeutic abortions, except as specifically stated in the section Complications of Pregnancy in the PART called WHAT IS COVERED.

MEDICAL EQUIPMENT AND SUPPLIES

Including but not limited to orthopedic shoes or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, supplies for comfort, hygiene or beautification, disposable sheaths and supplies, correction appliances or support appliances and supplies such as stockings except as specifically stated in the PART called WHAT IS COVERED.

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MENTAL HEALTH CARE

Treatment of Mental Health Care or psychological testing except as specifically stated under the benefit sections (for Severe Mental Illness) in this Policy. **However, medical services provided to treat medical conditions that are caused by behavior of the Policyholder that may be associated with mental or nervous conditions, for example, self-inflicted injuries, are not subject to these limitations.**

NON-DUPLICATION OF MEDICARE

We will not provide benefits that duplicate any benefits you would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which you can enroll without paying additional premium. However, if you have to pay an additional premium to enroll in Part A, B, C, or D of Medicare this exclusion will apply to that particular Part of Medicare for which you must pay only if you have enrolled in that Part.

If you have Medicare, your Medicare coverage will not affect the services covered under this Policy, except as follows:

1. Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and under this Policy.
2. If you receive a service that is covered both by Medicare and under this Policy, our coverage will apply only to the Medicare deductibles, coinsurance and other charges for Covered Services that you must pay over and above what's payable by your Medicare coverage.
3. For a particular claim, the combination of Medicare benefits and the benefits we will provide under this Policy for that claim will not be more than the Allowable Charge you have incurred for the Covered Services you received.

We will apply toward your Deductible any expenses paid by Medicare for services covered under this Policy, except for expenses paid under Medicare Part D.

The Policyholder who is Medicare disabled and/or 65 years of age or older may apply for an Anthem Nevada Plan which supplements Medicare benefits. **SERVICES, BENEFITS AND PREMIUMS UNDER A MEDICARE SUPPLEMENT PLAN WILL NOT BE THE SAME AS THOSE PROVIDED UNDER THIS POLICY.**

NONMEDICAL EXPENSES

NOT COVERED BEFORE YOUR EFFECTIVE DATE OR SERVICES RECEIVED AFTER YOUR COVERAGE ENDS
Services received before your Effective Date or received after your coverage ends.

NOT MEDICALLY NECESSARY

Any services or supplies that are:

- not Medically Necessary,
- not specifically described in this Policy, and
- part of a treatment plan for non-Covered Services or which are required to treat medical conditions which are a direct and predictable complication or consequence of non-Covered Services.

ORTHOPEDIC SHOES

except when joined to braces or shoe inserts.

OTHER DENTAL SERVICES

Dentures, bridges, crowns, caps, clasps, habit appliances, partials or other dental prostheses, Dental Services, extractions of teeth or treatment to the teeth or gums, except as specifically stated for dental care under the benefit sections of this Policy. **Dental Implants** (materials implanted into or on bone or soft tissue) or any associated procedure as part of the implantation or removal of implants. **Orthodontic Services**, braces, and other orthodontic appliances, except as specifically provided or arranged by us under the section called Dental Services in the PART called WHAT IS COVERED.

OTHER VISION CARE AND CERTAIN EYE SURGERIES

Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, routine eye refractions, and certain eye surgeries or any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia), except as specifically stated under the Vision sections in the PARTS called BENEFITS SUMMARY and WHAT IS COVERED.

OUTDOOR TREATMENT PROGRAMS

OUTPATIENT DRUGS AND MEDICATIONS NOT FROM A PHARMACY

Any Drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated under the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.

OUTPATIENT SPEECH THERAPY

Except following surgery, injury, or non-congenital organic disease as specifically described in this Policy.

OVER THE COUNTER PRODUCTS

Items available without a prescription including bandages, thermometers, home test kits like pregnancy tests and HIV test kits.

PERSONAL COMFORT ITEMS

Items which are furnished primarily for your comfort or convenience. Air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for comfort, hygiene or beautification.

PRE-EXISTING CONDITIONS

For members age 19 or older, no payment will be made for services or supplies for the treatment of a Pre-existing Condition during a period of twelve (12) months following your Effective Date. However, we may apply creditable coverage to satisfy or partially satisfy the twelve (12) month period if the length of time between the ending date of your prior coverage and your Effective Date under this Policy did not exceed sixty-three (63) days only if such prior coverage was with an Anthem individual plan.

PRIVATE DUTY NURSING

Inpatient or outpatient services of a private duty nurse unless we determine in advance that such services are Medically Necessary or as specifically covered under the PART called WHAT IS COVERED.

ROUTINE PHYSICAL EXAMS

or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except when covered during Office Visits as described in the Office Visits section under the PART called BENEFITS SUMMARY.

SERVICES FOR SOMEONE OTHER THAN THE POLICYHOLDER

Any person other than the Policyholder, including but not limited to the Policyholder's dependents, such as spouse, domestic partner, legal ward, natural child, adopted child and/or newborn child.

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SERVICES FOR WHICH YOU ARE NOT LEGALLY OBLIGATED TO PAY

or for which no charge would be made if you did not have a health plan or insurance coverage.

SERVICES FROM RELATIVES

Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.

SEX CHANGE

Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.

SEXUAL DYSFUNCTION

Services or prescriptions for the treatment of sexual dysfunction or impotence.

SKILLED NURSING FACILITY CARE**TELEPHONE, FACSIMILE MACHINE OR WEB CONSULTATIONS****TRANSPORTATION**

Commercial transport (air or ground), private aviation, or air taxi services, transportation by private automobile commercial or public transportation or wheelchair ambulance. Ambulance transport if the Policyholder could have been transported by automobile, commercial or public transportation without endangering their health or safety.

UNLISTED SERVICES

Services not specifically listed in this Policy as Covered Services.

WEIGHT REDUCTION

Services primarily for weight reduction or treatment of obesity or any care which involves weight reduction as the main method of treatment including bariatric surgery.

WORKERS' COMPENSATION

Any condition for which benefits are recovered or can be recovered either by any workers' compensation law or similar law even if you do not claim those benefits except for corporate officers who may opt out of Workers' Compensation coverage. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to Workers' Compensation law or similar law, we will provide the benefits of this plan subject to a conditional claims payment during an appeal process if a reimbursement agreement is signed.

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