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	
DEDUCTIBLE	$5,000 per calendar Year			Amounts paid for the first four (4) Office Visits in a calendar Year, emergency room services, ambulance services, vision benefits and certain preventive care services are not subject to your Deductible. Please see the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE for more information.
LIFETIME MEDICAL BENEFIT MAXIMUM	$5,000,000 lifetime medical maximum benefits paid by Anthem.			The lifetime medical benefit maximum applies to any payments that Anthem makes under this Policy, or under any other product that is medically underwritten by Anthem.
OUT-OF-POCKET MAXIMUM	$5,000 per calendar Year	$10,000 per calendar Year		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, certain preventive care services, and the additional amount for not obtaining Preservice Review. 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. Please check the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE for more information.

OFFICE VISITS	You pay a $20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year. For subsequent Office Visits, you pay all charges up to the Contracted Amount. After your Deductible has been satisfied, you do not pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year**.**	You pay 30% of Contracted Amount per Office Visit for the first four (4) Office Visits in a calendar Year. 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.	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. For subsequent Office Visits, you pay all billed charges. 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.	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. 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. 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.
PROFESSIONAL SERVICES	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.	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 Physicians office visit. Refer to the section Professional Services under the PART called WHAT IS COVERED for a detailed description of Covered Services under this benefit.

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 **plus** 30% of billed charges for each emergency room visit. This Copayment plus the Coinsurance 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. Copayments and Coinsurance amounts will not be applied to the Deductible or out-of-pocket maximum, and you will continue to be responsible for Copayment and Coinsurance 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 Contacted 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.
PREVENTIVE CARE	**Office Visits:** You pay a $20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year. For subsequent Office Visits, you pay all charges up to the Contracted Amount. After your Deductible has been satisfied, you do not pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year. **Professional Services (in the absence of an Office Visit):** After your Deductible has been satisfied, you do not pay any Coinsurance.	**Office Visits:** You pay 30% of Contracted Amount per Office Visit for the first four (4) Office Visits in a calendar Year. 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.	**Office Visits:** 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. For subsequent Office Visits, you pay all billed charges. 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. **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.	No Deductible is required for the first four (4) Office Visits (professional and Preventive Services Office Visits combined), PPO, 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 for the first four (4) 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 preventive services that are not subject to the Deductible.

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	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. **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. 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.
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.	
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.	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 No Deductible is required for Ambulance services.
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.	Anthem will cover up to a maximum payment of $1,500 for Medically Necessary treatment for detoxification; Anthem will cover up to a maximum payment of $9,000 for inpatient or outpatient rehabilitation; and Anthem will cover up to a maximum payment of $2,500 for counseling, per calendar Year.
PROGRAMS TO STOP TOBACCO USE	You pay all charges **except** a $50 lifetime reimbursement.			
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.

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	
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.	Limited to a lifetime maximum Anthem payment of $10,000; PPO , Participating and Non-Participating Providers combined. 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.	You pay no more than what you would have paid if services had been received from a PPO or Participating Provider.	**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.*	**Non-Participating Provider:** You pay 30% of the Maximum Benefit Allowance **plus** all charges in excess of the Maximum Benefit Allowance.	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. Please be advised that BlueCard PPO Providers are different than Anthem PPO Providers.
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.*	**Non-Participating Provider:** You pay 30% of the Maximum Benefit Allowance **plus** all charges in excess of the Maximum Benefit Allowance.	*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**
PRESCRIPTION DRUG COVERAGE **Retail Pharmacies:**			Your Prescription Drug benefit (including mail service Prescription Drugs) covers **only** Generic Prescription Drugs listed on the Anthem Generic Prescription Drug List/Formulary.
Generic Drugs Including insulin and metabolic foods	You pay a $10 Copayment for each Prescription and/or refill for each 34-day supply.	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.	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. Outpatient Generic Prescription Drug benefits are separate from your medical benefits.
Self-Administered Injectable Drugs	You pay 30% of the Contracted Amount for Drugs listed on the Anthem Generic Prescription Drug List/Formulary, except for insulin.	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.	**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**. 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.
When You Order By Mail:			
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.	Not Applicable.	

Questions? Visit our web site www.Medicoverage.com/TONIK or call customer service (800) 930-7956 opt. 2

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, reike therapy, herbal medicine, vitamin or dietary products or therapies, natuorpathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial 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 except as provided herein.

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.

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
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.

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.