Individual Tonik℠ $5,000

Thrill-Seeker (06BK)

Effective 9-23-2010

Note: Coverage is provided by Anthem Blue Cross Life and Health Insurance Company (known as "Anthem Blue Cross Life and Health" "Anthem"), which is an affiliate of Anthem Blue Cross, and Anthem Blue Cross will administer your coverage for Anthem Blue Cross Life and Health.

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BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

YOUR MEDICAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	INFORMATION YOU SHOULD KNOW
DEDUCTIBLE	$5,000 per calendar Year.		
OUT-OF-POCKET MAXIMUM	$5,000 Deductible per calendar Year, Participating and Non-Participating Providers combined.	$10,000 per calendar Year.	
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 of the Negotiated Fee Rate. 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 50% of Covered Expense **plus** all charges in excess of Covered Expense after meeting your annual Deductible.	No Deductible is required for the first four (4) Office Visits when you go to a participating provider. An Office Visit is when you go to the Physician's office and have one or more of **ONLY** the following three services provided: 1. History (gathering of information on an illness or injury 2. Examination 3. Medical Decision Making (the Physician's actual diagnosis and treatment plan) The Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology, and radiology) or any other services performed other than or in addition to any of the three services specifically listed above. When you go to a participating provider, Copayments 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 after meeting your annual Deductible.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense after meeting you annual Deductible.	This benefit is separate from professional services covered under the Office Visit benefit (see above). Refer to the section PROFESSIONAL SERVICES under the PART called WHAT IS COVERED for a detailed description of Covered Services.

EMERGENCY ROOM in a Non-Medical Emergency or Non-Serious Accidental Injury	You do not pay any Coinsurance.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	
EMERGENCY ROOM in a Medical Emergency or Serious Accident	You do not pay any Coinsurance.	You do not pay any Coinsurance.	
INPATIENT HOSPITAL	You do not pay any Coinsurance.	You pay all charges **except** $650 per day.	A Center of Medical Excellence (CME) Network has been established for transplants and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only when performed by a Participating Provider at an approved CME facility, except for Medical Emergencies. For more information, please see the section entitled CENTERS OF MEDCIAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY under the PART called WHAT IS COVERED. Does not include treatment for Mental or Nervous Disorders and Substance Abuse **(except for Severe Mental Illness and Serious Emotional Disturbances of a Child)**.
OUTPATIENT HOSPITAL AMBULATORY SURGICAL CENTER	You do not pay any Coinsurance.	You pay all charges **except** $380 per day.	Does not include treatment for Mental or Nervous Disorders and Substance Abuse **(except for Severe Mental Illness and Serious Emotional Disturbances of a Child)**.
VISION	You pay $50 for one routine vision exam each calendar Year and a pair of eye glasses or contact lenses every 24 months.		No Deductible is required. 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. For additional benefits, please see the vision section.

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)			
YOUR MEDICAL BENEFITS	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**	**INFORMATION YOU SHOULD KNOW**
PREVENTIVE CARE	**Office Visits:** You pay a $0 Copayment you do not pay any Copayment or Coinsurance for Office Visits. **Professional Services (in the absence of an Office Visit):** you do not pay any Coinsurance.	**Office Visits:** You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense after meeting your annual Deductible. **Professional Services (in the absence of an Office Visit):** After your Deductible has been satisfied, you pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	Copayments paid for Non-Participating Office Visits will not be applied to the Deductible or out-of-pocket maximum.
	You pay $0 Copayment per HealthyCheck Center visit. You pay $0 Copayment per HealthyCheck Center visit for the additional services option (for adults age 18 and above).		

PHYSICAL THERAPY **OCCUPATIONAL THERAPY** **AND/OR** **CHIROPRACTIC CARE**	You do not pay any Coinsurance.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	Limited to 24 visits per calendar Year, Participating and Non-Participating Providers combined. 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 INJURY	You do not pay any Coinsurance.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	
AMBULANCE Other than in a Medical Emergency or without an Authorized Referral	You do not pay any Coinsurance.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	
AMBULANCE In a Medical Emergency or with an Authorized Referral	You do not pay any Coinsurance.	You do not pay any Coinsurance..	
MENTAL HEALTH CARE **AND** **SUBSTANCE ABUSE**			
□ **Professional Services** (inpatient and outpatient Physician services)	You do not pay any Coinsurance.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	**Professional Services:** Limited to 1 visit per day, 20 visits per calendar Year, Participating and Non-Participating Providers combined.

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)			
YOUR MEDICAL BENEFITS	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**	**INFORMATION YOU SHOULD KNOW**
□ **Inpatient Hospital and Day Treatment Program**	You do not pay any Coinsurance. **Services for Severe Mental Illness and Serious Emotional Disturbances of a Child:** Benefits provided the same as for any other medical condition.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense. **Services for Severe Mental Illness and Serious Emotional Disturbances of a Child:** Benefits provided the same as for any other medical condition.	**Inpatient Hospital and Day Treatment Program:** Benefit is for treatment of Mental or Nervous Disorders or Substance Abuse and does not include treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child. Preservice review required for all facility based treatment, as well as outpatient professional services after the twelfth (12^{th}) visit. Preservice review required for outpatient professional services after the twelfth (12^{th}) visit and all facility based treatment. 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.

PROGRAMS TO STOP SMOKING	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. Anthem pays 100% of the Negotiated Fee Rate.		
OTHER ELIGIBLE PROVIDERS □ Blood Bank □ Dentist (D.D.S.) □ Dispensing Optician □ Speech Pathologist □ Speech Therapist □ Audiologist □ Respiratory Therapist	You pay all charges in excess of Covered Expense.		These providers do not enter into participating agreements with us, and they must be licensed according to state and local laws to provide covered medical services. Covered Services received from dispensing optician under this benefit is separate from Covered Services received from a dispensing optician under the "VISION" benefit.
MEDICAL SUPPLIES EQUIPMENT AND FOOTWEAR	You do not pay any Coinsurance.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	Footwear is limited to a maximum Anthem payment of $400 per calendar Year, Participating and Non-Participating Providers combined.
SKILLED NURSING FACILITY	You do not pay any Coinsurance.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	Limited to 100 days per calendar Year, Participating and Non-Participating Providers combined. Does not include treatment for Mental or Nervous Disorders and Substance Abuse **(except for the treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child).**
HOME HEALTH CARE	You do not pay any Coinsurance.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	Limited to 60 visits per calendar Year, up to four (4) hours each visit, Participating and Non-Participating Providers combined.

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)			
YOUR MEDICAL BENEFITS	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**	**INFORMATION YOU SHOULD KNOW**
INFUSION THERAPY	You do not pay any Coinsurance.	**Administrative and Professional Services:** You pay all charges in excess of $50 per day for all expenses (except Drugs). **Drugs:** You pay all charges in excess of the Average Wholesale Price (AWP) of the Drug. Combined maximum Anthem payment (for administrative, professional and Drugs) will not exceed $500 per day.	
HOSPICE	You do not pay any Coinsurance.	You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense.	
FOREIGN COUNTRY PROVIDER	For initial treatment of a Medical Emergency only. You pay all charges in excess of Covered Expense.		**You are responsible, at your expense, for obtaining an English language translation of foreign country provider claims and medical records.**

SPECIAL CIRCUMSTANCES FOR AUTHORIZED REFERRALS	This benefit does not apply to Participating Providers.	You pay all charges in excess of Covered Expense.	**Non-Participating Providers:** Physician, Hospital (inpatient or outpatient), Ambulatory Surgical Center
SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES WITHIN CALIFORNIA	You do not pay any Coinsurance.	**Professional Services:** You pay all charges in excess of Covered Expense. **Emergency Room:** You do not pay any Coinsurance. **Hospital and Non-Contracting Hospital:** You pay all charges in excess of Covered Expense. **Ambulatory Surgical Center:** You pay all charges in excess of Covered Expense. **Ambulance:** You pay all charges in excess of Covered Expense.	

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)			
YOUR MEDICAL BENEFITS	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**	**INFORMATION YOU SHOULD KNOW**
SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES OUTSIDE CALIFORNIA □ **Physician**	**PPO Provider:** You do not pay any Coinsurance. **Traditional Provider:** You do not pay any Coinsurance.	You pay all charges in excess of Covered Expense.	**BLUECARD PROGRAM** For information about the BlueCard Program, including descriptions of the types of providers you may encounter outside California (i.e., PPO, Traditional and Non-Participating Providers), please see the PART called WHEN YOU TRAVEL OUTSIDE CALIFORNIA. Deductible is required (including emergency room services received outside California). Amounts you pay for Covered Expense will be applied to the calendar Year Deductible and out-of-pocket maximum.
□ **Hospital, Ambulatory Surgical Center, Ambulance or Emergency Room**	**PPO Provider:** You do not pay any Coinsurance. **Traditional Provider:** You do not pay any Coinsurance.	**Hospital:** You pay all charges in excess of Covered Expense. **Ambulatory Surgical Center Ambulance or Emergency Room:** You pay all charges in excess of Covered Expense.	

ELECTIVE SERVICES OUTSIDE CA (NON-MEDICAL EMERGENCY) □ Office Visits	**PPO Provider:** You pay a $20 Copayment per Office Visit for the first four (4) Office Visits. For subsequent Office Visits, you pay all of the Negotiated Fee Rate. After your Deductible has been satisfied, you do not pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year. **Traditional Provider:** You pay 50% of the BlueCard provider's Negotiated Price.***	You pay 50% of the BlueCard provider's Negotiated Price **plus** all charges in excess of the BlueCard provider's Negotiated Price after meeting your annual Deductible.	**BLUECARD PROGRAM** No Deductible is required for the first four (4) Office Visits when you go to a BlueCard provider. An Office Visit is when you go to the Physician's office and have one or more of **ONLY** the following three services provided: 1. History (gathering of information on an illness or injury 2. Examination 3. Medical Decision Making (the Physician's actual diagnosis and treatment plan) The Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology, and radiology) or any other services performed other than or in addition to any of the three services specifically listed above. When you go to a BlueCard provider, Copayments 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	**PPO Provider:** You do not pay any Coinsurance after meeting your Deductible. **Traditional Provider:** You pay 50% of the BlueCard provider's Negotiated Price.***	You pay 50% of the BlueCard provider's Negotiated Price **plus** all charges in excess of the BlueCard provider's Negotiated Price after meeting your Deductible. .	For information about the BlueCard Program, including descriptions of the types of providers you may encounter outside California (i.e., PPO, Traditional and Non-Participating Providers), please see the PART called WHEN YOU TRAVEL OUTSIDE CALIFORNIA. ***If there are no BlueCard PPO providers in the area, you do not pay any Coinsurance.

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)			
YOUR MEDICAL BENEFITS	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**	**INFORMATION YOU SHOULD KNOW**
□ **Hospital or Ambulatory Surgical Center**	**PPO Provider:** You do not pay any Coinsurance. **Traditional Provider:** You pay 50% of the BlueCard provider's Negotiated Price.***	**Inpatient Hospital:** You pay all charges **except** $650 per day. **Outpatient Hospital and/or Ambulatory Surgical Centers:** You pay all charges **except** $380 per day.	

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**
RETAIL PHARMACIES			
□ **Generic Drugs**	You pay a $15 Copayment for each Prescription and/or refill for each 30-day supply.	The rate of reimbursement is 50% of the Drug Limited Fee Schedule amount, less the Copayment/Coinsurance as stated for Participating Pharmacies.	Your Prescription Drug benefit (including mail service Prescription Drugs) covers **only** Generic Prescription Drugs listed on the Blue Cross Generic Prescription Drug Formulary.
□ **Self-Administered Injectable Drugs**	You pay 30% of the Negotiated Fee (except for insulin) for Drugs listed on the Blue Cross Generic Prescription Drug Formulary.		Outpatient Generic Prescription Drug benefits are separate from your medical benefits.
WHEN YOU ORDER BY MAIL			**This is a 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**.
□ **Generic Drugs**	You pay a $15 Copayment for each Prescription and/or refill for each 30-day supply. You pay a $30 Copayment for each Prescription and/or refill up to a maximum 60-day supply.	Not Applicable.	

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

COMMERCIAL WEIGHT LOSS
Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Policy. This exclusion includes, but is not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity.

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.

DURABLE MEDICAL EQUIPMENT
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.

EDUCATIONAL, VOCATIONAL, AND TRAINING SERVICES
except as specifically listed as being covered under 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 Covered Expense.

EXPERIMENTAL OR INVESTIGATIVE
Medical, surgical and/or other procedures, services, products, drugs or devices (including implants), except as specifically stated under CANCER CLINICAL TRIALS in the PART called WHAT IS COVERED, which are either:

- experimental or investigational or which are not recognized in accord with generally accepted professional medical standards as being safe and effective or use is in question, or
- outmoded or not efficacious, such as those defined by the Federal Medicare programs or drugs or devices that are not approved by the Food and Drug Administration, or
- services associated with either the first or second bullet point above.

FOOD AND/OR DIETARY SUPPLEMENTS
No benefits are provided for nutritional and/or dietary supplements except as provided in this Policy or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

GOVERNMENT SERVICES
Any services you actually received that were provided by a local, state or federal government agency, or by a public school system or school district, except when payment under this Policy is expressly required by federal or state law. Anthem will not cover payment for these services that you have actually received if you are not required to pay for them or they are given to you for free. Veterans' Administration Hospital and Military Treatment Facilities will be considered for payment according to current legislation.

HEALTH CLUBS
Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

HEARING AIDS
Hearing aids and routine hearing tests.

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

MATERNITY/PREGNANCY CARE
No benefits are provided for pregnancy, maternity care or abortions.

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE
Treatment of Mental or Nervous Disorders and Substance Abuse (including nicotine use) or psychological testing except as specifically stated under the benefit sections (for MENTAL HEALTH CARE AND SUBSTANCE ABUSE) 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 and treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child, are not subject to these limitations.**

NON-CONTRACTING HOSPITAL
No benefits are provided for care or treatment furnished in a Non-Contracting Hospital, **except** for a Medical Emergency as defined in the PART called IMPORTANT TERMS TO KNOW. This exclusion applies **only** in California.

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 allowed Covered Expense 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 a Blue Cross of California 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.

NON-LICENSED PROVIDERS
Treatment or services provided by a non-licensed health care provider and treatment or services for which a health care provider license is not required. This includes treatment or services provided by a non-licensed provider under the supervision of licensed Physician, except as specifically provided or arranged by us.

NOT COVERED BEFORE YOUR EFFECTIVE DATE OR AFTER YOUR COVERAGE ENDS
Services received before your Effective Date or during an inpatient stay that began before your Effective Date. Services 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.

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, and as stated in the vision section.

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.

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 six (6) months following your Effective Date. However, we may apply Creditable Coverage to satisfy or partially satisfy the six (6) 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-two (62) days.

PRIVATE DUTY NURSING
Inpatient or outpatient services of a private duty nurse unless we determine in advance that such services are Medically Necessary.

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 as provided 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, newborn, legal ward, natural and /or adopted 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, except services received at a non-governmental charitable research Hospital.

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.

SERVICES THAT DO NOT REQUIRE LICENSURE
Services or the supervision of services that are not required to be rendered by a licensed Provider unless specifically listed as being covered under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM.

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.

SUPERVISION OF NON-LICENSED PROVIDER
Services for the supervision of a non-licensed Provider.

SURROGACY
No benefits are provided for any services or supplies provided to a person not covered under the Policy in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

TELEPHONE AND FACSIMILE MACHINE CONSULTATIONS

TRANSPORTATION AND TRAVEL EXPENSE
Expense incurred for transportation, except as specifically stated in the AMBULANCE, TRANSPLANT TRAVEL EXPENSE and BARIATRIC TRAVEL EXPENSE provisions of COMPREHENSIVE BENEFITS: WHAT IS COVERED. Mileage reimbursement except as specifically stated in the TRANSPLANT TRAVEL

EXPENSE and BARIATRIC TRAVEL EXPENSE provisions of COMPREHENSIVE BENEFITS: WHAT IS COVERED and approved by us. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.

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 except Medically Necessary treatment of morbid obesity (which requires Preservice Review), including bariatric surgery as stated under the PART called WHAT IS COVERED, in the section entitled CENTERS OF MEDICAL EXCELLENCE (CME) FOR TRANSPLANTS AND 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. 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 for such conditions, subject to our right to a lien or other recovery under section 4903 of the California Labor Code or other applicable law.