

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	\$3,000 per calendar Year.		
LIFETIME MEDICAL BENEFIT MAXIMUM	\$5,000,000 lifetime maximum benefits paid by BC Life.		
OUT-OF-POCKET MAXIMUM	\$3,000 Deductible per calendar Year, Participating and Non-Participating Providers combined.	\$10,000 per calendar Year.	
OFFICE VISITS	<p>You pay a \$30 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all of the Negotiated Fee Rate.</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 50% of Covered Expense plus all charges in excess of Covered Expense per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all charges.</p> <p>After your Deductible has been satisfied, you pay 50% of Covered Expense plus all charges in excess of Covered Expense for remainder of that calendar Year.</p>	<p>No Deductible is required for the first four (4) Office Visits (Professional and Adult Preventive Services Office Visits combined), 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/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	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	<p>This benefit is separate from professional services covered under the Office Visit benefit (see above).</p> <p>Refer to the section PROFESSIONAL SERVICES under the PART called WHAT IS COVERED for a detailed description of Covered Services.</p>

EMERGENCY ROOM	<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 plus all charges in excess of Covered Expense for each emergency room visit.</p> <p>This benefit 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>Copayments/Coinsurance 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>
INPATIENT HOSPITAL	<p>You do not pay any Coinsurance.</p>	<p>You pay all charges except \$650 per day.</p>	<p>A Center of Expertise (COE) 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 COE facility, except for Medical Emergencies. For more information, please see the section entitled CENTERS OF EXPERTISE (COE) FOR TRANSPLANTS AND BARIATRIC SURGERY under the PART called WHAT IS COVERED.</p> <p>Does not include treatment for Mental or Nervous Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).</p>
OUTPATIENT HOSPITAL AMBULATORY SURGICAL CENTER	<p>You do not pay any Coinsurance.</p>	<p>You pay all charges except \$380 per day.</p>	<p>Does not include treatment for Mental or Nervous Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).</p>
VISION	<p>You pay all charges except \$50 per calendar Year.</p>		<p>No Deductible is required.</p> <p>Covered Services received under this benefit are separate from Covered Services received under any other benefit described in this Policy.</p> <p>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.</p>

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<p>PREVENTIVE CARE Adult Preventive Services are provided at your Physician's office and not at the HealthyCheck Centers.</p> <p>Adult preventive services include an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, cervical and ovarian cancer screening tests, PSA (Prostatic Specific Antigen) testing, and the Office Visit related to these services.</p>	<p>Office Visits: You pay a \$30 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all of the Negotiated Fee Rate.</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>Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you do not pay any Coinsurance.</p>	<p>Office Visits: You pay 50% of Covered Expense plus all charges in excess of Covered Expense per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all charges.</p> <p>After your Deductible has been satisfied, you pay 50% of Covered Expense plus all charges in excess of Covered Expense 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 50% of Covered Expense plus all charges in excess of Covered Expense.</p>	<p>No Deductible is required for the first four (4) Office Visits (Professional and Adult Preventive Services Office Visits combined), 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/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>HealthyCheck Centers (for the Policyholder age 7 years and above)</p>	<p>You pay \$25 per HealthyCheck Center visit.</p> <p>You pay \$75 per HealthyCheck Center visit for the additional services option (for adults age 19 and above).</p>	<p>This benefit does not apply to Non-Participating Providers.</p>	<p>No Deductible is required. Copayments paid at HealthyCheck Centers will not be applied to the Deductible.</p>

PHYSICAL THERAPY OCCUPATIONAL THERAPY AND/OR CHIROPRACTIC CARE	You do not pay any Coinsurance.	You pay all charges except \$25 per visit.	Limited to 12 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	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	
MENTAL HEALTH CARE AND SUBSTANCE ABUSE <input type="checkbox"/> Professional Services (inpatient and outpatient Physician services) <input type="checkbox"/> Inpatient Hospital and Day Treatment Program	<p>You pay all of the Negotiated Fee Rate except \$25 per visit.</p> <p>You pay all of the Negotiated Fee Rate except \$175 per day.</p> <p>Services for Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits provided the same as for any other medical condition.</p>	<p>You pay all charges except \$25 per visit.</p> <p>You pay all charges except \$175 per day.</p> <p>Services for Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits provided the same as for any other medical condition.</p>	<p>Professional Services: Limited to 1 visit per day, 20 visits per calendar Year, Participating and Non-Participating Providers combined.</p> <p>Inpatient Hospital and Day Treatment Program: Benefits are provided up to a maximum BC Life payment of \$5,250 per calendar Year (up to a maximum of 30 days per calendar Year), Participating Providers and Non-Participating Providers combined.</p> <p>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.</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>

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YOUR MEDICAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	INFORMATION YOU SHOULD KNOW
PROGRAMS TO STOP SMOKING	You pay all charges except a \$50 lifetime reimbursement.		
OTHER ELIGIBLE PROVIDERS <input type="checkbox"/> Blood Bank <input type="checkbox"/> Dentist (D.D.S.) <input type="checkbox"/> Dispensing Optician <input type="checkbox"/> Speech Pathologist <input type="checkbox"/> Speech Therapist <input type="checkbox"/> Audiologist <input type="checkbox"/> 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 BC Life payment of \$400 per calendar Year, Participating and Non-Participating Providers combined.
SKILLED NURSING FACILITY	You do not pay any Coinsurance.	You pay all charges except \$150 per day.	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 Severe Mental Illness and Serious Emotional Disturbances of a Child).
HOME HEALTH CARE	You do not pay any Coinsurance.	You pay all charges except \$75 per visit.	Limited to 60 visits per calendar Year, up to four (4) hours each visit, Participating and Non-Participating Providers combined.

INFUSION THERAPY	You do not pay any Coinsurance.	<p>Administrative and Professional Services: You pay all charges in excess of \$50 per day for all expenses (except Drugs).</p> <p>Drugs: You pay all charges in excess of the Average Wholesale Price (AWP) of the Drug.</p> <p>Combined maximum BC Life payment (for administrative, professional and Drugs) will not exceed \$500 per day.</p>	
HOSPICE	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	Limited to a lifetime maximum BC Life payment of \$10,000, Participating and Non-Participating Providers combined.
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

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YOUR MEDICAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	INFORMATION YOU SHOULD KNOW
<p>SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES WITHIN CALIFORNIA</p>	<p>Benefits are the same as non-Medical Emergency benefits.</p>	<p>Professional Services: You pay all charges in excess of Covered Expense.</p> <p>Emergency Room: You pay a \$100 Copayment plus all charges in excess of Covered Expense for each emergency room visit.</p> <p>This benefit covers the emergency room visit and Covered Services that you receive in the emergency room during that visit.</p> <p>Hospital and Non-Contracting Hospital: You pay all charges in excess of Covered Expense for the first 48 hours. After 48 hours, you pay all charges except \$650 per day.*</p> <p>Ambulatory Surgical Center: You pay all charges in excess of Covered Expense.</p> <p>Ambulance: You pay all charges in excess of Covered Expense.</p>	<p>Emergency Room: 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.</p> <p>Copayments /Coinsurance amounts will not be not applied to the Deductible or out-of-pocket maximum, and you will continue to be required to pay Copayments/Coinsurance after your Deductible and out-of-pocket maximum have been satisfied.</p> <p>Hospital and Non-Contracting Hospital: *If you can demonstrate to BC Life that your medical condition reasonably prevented transfer to a Participating facility after the first 48 hours, then your payment will remain at all charges in excess of Covered Expense until your medical condition permits transfer to a Participating facility.</p>

<p>SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES OUTSIDE CALIFORNIA</p>			
<p>□ Physician</p>	<p>PPO Provider: You do not pay any Coinsurance.</p> <p>Traditional Provider: You do not pay any Coinsurance.</p>	<p>You pay all charges in excess of Covered Expense.</p>	<p>BLUECARD PROGRAM</p> <p>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.</p> <p>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.</p>
<p>□ Hospital, Ambulatory Surgical Center, Ambulance or Emergency Room</p>	<p>PPO Provider: You do not pay any Coinsurance.</p> <p>Traditional Provider: You do not pay any Coinsurance.</p>	<p>Hospital: You pay all charges in excess of Covered Expense for the first 48 hours. After 48 hours, you pay all charges except \$650 per day.**</p> <p>Ambulatory Surgical Center Ambulance or Emergency Room: You pay all charges in excess of Covered Expense.</p>	<p>**If you can demonstrate to Blue Cross and/or Blue Shield that your medical condition reasonably prevented transfer to a BlueCard PPO or Traditional facility after the first 48 hours, then your payment will remain at all charges in excess of Covered Expense until your medical condition permits transfer to a PPO or Traditional facility.</p>

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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>RETAIL PHARMACIES</p> <ul style="list-style-type: none"> □ Generic Drugs □ Self-Administered Injectable Drugs <p>WHEN YOU ORDER BY MAIL</p> <ul style="list-style-type: none"> □ Generic Drugs 	<p>You pay a \$10 Copayment for each Prescription and/or refill for each 30-day supply.</p> <p>You pay 30% of the Negotiated Fee (except for Insulin) for Drugs listed on the Blue Cross Generic Prescription Drug Formulary.</p> <p>You pay a \$10 Copayment for each Prescription and/or refill for each 30-day supply.</p> <p>You pay a \$20 Copayment for each Prescription and/or refill up to a maximum 60-day supply.</p>	<p>The rate of reimbursement is 50% of the Drug Limited Fee Schedule amount, less the Copayment/Coinsurance as stated for Participating Pharmacies.</p> <p>Not Applicable.</p>	<p>Your Prescription Drug benefit (including mail service Prescription Drugs) covers only Generic Prescription Drugs listed on the Blue Cross Generic Prescription Drug Formulary.</p> <p>Outpatient Generic Prescription Drug benefits are separate from your medical benefits.</p> <p>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.</p>

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

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 SERVICES AND NUTRITIONAL COUNSELING

except as specifically provided or arranged by us under the Diabetes Outpatient Self-Management Training Program provision 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 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

except for formulas and special food products as specifically stated under Phenylketonuria (PKU) in the PART called WHAT IS COVERED. They must be prescribed by a Physician in consultation with a metabolic disease specialist and deemed Medically Necessary to prevent complications of PKU. Coverage is only to the extent that the prescribed formulas and special food products exceed the cost of a normal diet.

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GOVERNMENT SERVICES

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

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.**

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.

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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.

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.

TELEPHONE AND FACSIMILE MACHINE CONSULTATIONS**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 EXPERTISE (COE) 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.

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