

American Specialty Health Plans of California, Inc.
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**CHIROPRACTIC & ACUPUNCTURE BENEFIT
COMBINED
EVIDENCE OF COVERAGE
AND
DISCLOSURE FORM**

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HOW TO USE ASH PLANS

This booklet is your Combined Evidence of Coverage and Disclosure Form (“Combined EOC”). It explains what American Specialty Health Plans of California, Inc. (“ASH Plans”) covers and does not cover. Please read this booklet completely and carefully, including the sections that apply to your special health care needs. Also read your Schedule of Benefits attached hereto as Appendix A, which lists copayments and other fees.

This Combined EOC constitutes only a summary of the Health Plan contract offered by ASH Plans. The Health Plan contract must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the Health Plan contract is available from your Group or from ASH Plans upon request.

ASH Plans is a kind of group health insurance. Group health insurance is insurance that you get through a group, such as an employer. Even if you have belonged to a health plan before, take some time to learn about ASH Plans. This chapter tells you about:

- How to Contact ASH Plans
- The ASH Plans Service Area
- The ASH Plans network
- Language and communication assistance
- How to get healthcare when you need it

IMPORTANT: If you are having trouble reading this document and have language needs other than English, we can have somebody help you. You may call 1-800-678-9133 Monday-Friday 5 a.m. to 6 p.m. Pacific Time. There is no fee for this service. Because this document may require action by you, you are encouraged to call as soon as possible.

How to Contact ASH Plans

Our Member Services office is here to help you. Please contact ASH Plans Member Services by:

Phone: 1-800-678-9133

Writing: P.O. Box 509002, San Diego, CA 92150-9002

Web site: www.ashcompanies.com. Go to the Member tab on www.ashcompanies.com and click on the ASH Plans of California link, or enter your member ID and other demographic information.

The ASH Plans Service Area

ASH Plans' Service Area is the State of California. You must live or work in the service area to become a member of ASH Plans. You must receive all health care services within the ASH Plans service area, unless you need Emergency Services or Urgent Services. If you move out of the service area or no longer work there you must tell ASH Plans.

The ASH Plans Network

- You must get your health care from providers who are in the network. Information on provider facilities including their location and description of the services provided may be obtained by asking for an ASH Plans Provider Directory. To request a Provider Directory, you may log in to www.ashcompanies.com and click on "Find a Provider" or Call 1-800-678-9133
- If you go to providers outside the network, you will have to pay all of the cost, unless you received Emergency Services, Urgent Services or pre-approval from ASH Plans.
- If you are new to ASH Plans or ASH Plans ends your provider's contract, you can continue to see your current doctor or other health care provider in some cases. This is called continuity of care. Please see the section entitled Continuity of Care for more information.

Language and Communication Assistance

Good communication with ASH Plans and with your providers is important. If English is not your first language, ASH Plans provides interpretation services.

- To ask for language services call ASH Plans at 1-800-678-9133
- If you are deaf, hard of hearing or have a speech impairment, you may also receive language assistance services by calling ASH Plans at 1-800-678-9133
- If you have a preferred language, please notify us of your personal language needs by calling 1-800-678-9133.

How to Get Health Care When You Need It

- A Member will have direct access to Contracted Chiropractors and Contracted Acupuncturists ("Contracted Providers") without obtaining a physician referral. A Member may contact a Contracted Provider to schedule a new patient examination. The care must be Medically Necessary for your health. Your provider and ASH Plans follow guidelines and policies to decide if the care is Medically Necessary. If you disagree with ASH Plans about whether a service you want is Medically Necessary, you can request an Independent Medical Review.
- The care must be a service that ASH Plans covers. Covered Services are also called benefits. To see what services ASH Plans covers, see the "Summary of Benefits" section of this Combined EOC.

- After you pay your copay ASH Plans pays the rest of the cost of the service, as long as the service you get is a covered benefit.

WHAT YOU PAY

This chapter tells you about your costs in ASH Plans. The costs you pay may include:

- Premiums
- Copays (copayments)

This chapter also tells you about:

- If you have to pay for care at the time you get it (Reimbursement Provisions)
- How to get reimbursed
- Your financial responsibility
- Maximum benefit
- ASH Plans payments
- Your liability
- If you have more than one health plan (Coordination of Benefits)

Premiums

A premium is the amount that ASH Plans charges each month for health care. Your Group will pay ASH Plans the Health Plan Premium on your behalf. You should contact your Group regarding any required employee contribution.

- The amount you pay is usually taken out of your paycheck each month. If you have questions about your premium, ask your Group.
- If the premium changes, ASH Plans will let your Group know in writing at least 30 days before the change. Usually, the premium changes only when your Group renews its contract with ASH Plans.

Copays (Copayments)

A Member receiving Covered Services will only be responsible for applicable Copayments. Copayments are listed in the Schedule of Benefits attached hereto as Appendix A. Such Copayments must be paid by the Member to the Contracted Provider when the services are provided. A Member may also obtain services not covered by ASH Plans at the Member's own expense.

If You Have to Pay for Care at the Time You Receive It

(Reimbursement Provisions)

ASH Plans will pay claims for Emergency Services or Urgent Services that are Covered Services. ASH Plans will also pay claims for other Covered Services that are not available and accessible to a Member through a Contracted Provider, but are provided upon a referral by ASH Plans.

You may be liable to a provider for such Covered Services if the provider is not a Contracted Provider with ASH Plans. If you must pay for Covered Services, ASH Plans will reimburse you.

How to Get Reimbursed:

When you receive a bill from a provider for Covered Services, you must file a claim with ASH Plans. If you have assigned benefits to the provider, ASH Plans will pay the provider. If you have paid the bill, ASH Plans will pay that amount to you. You must pay the Copayment for any Covered Services. In the event that ASH Plans fails to pay a non-Contracted Provider, you may be liable to the non-Contracted Provider for the cost of services.

Members must file claims for Emergency Services, Urgent Services or other Covered Services as soon as possible after receiving the Emergency Services, Urgent Services or other Covered Services. A Member must use ASH Plans' forms in filing a claim and should send the claim form to ASH Plans at the address listed on the claim form or to ASH Plans at:

American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002
Attention: Claims Department

ASH Plans will provide you with a claim form at your request. For more information regarding claims, and to obtain an ASH Plans claim form, you may call ASH Plans at 1-800-678-9133, visit our Web site at www.ashcompanies.com, or write ASH Plans at the address given immediately above.

Your Financial Responsibility

If you receive services that are not Covered Services, the provider who provided those services may bill you directly, and you—not ASH Plans—must pay the provider. You will have no right to request reimbursement from ASH Plans in such a situation, and ASH Plans will have no obligation to reimburse you for any such services.

There are various instances in which you might receive services from a provider that are not Covered Services, including, but not limited to, the following:

- You receive Covered Services, other than Emergency Services or Urgent Services, from a non-Contracted Provider without approval from ASH Plans.
- You agree to receive services that are not Covered Services. This might occur, for example, if you desire to receive services from a Contracted Provider that are excluded from coverage.

In situations such as those described above, ASH Plans will have no obligation to pay the provider for those services or to pay or reimburse you for those services.

There are other instances in which you might receive services that are not Covered Services including, but not limited to, the following:

- The person who received the services was not an ASH Plans Member at the time he or she received the services. This might occur, for example, if you receive services before you have met the eligibility requirements established by the Group or if you receive services after termination of your coverage under the Health Plan. It also might occur, for example, if you are not properly enrolled pursuant to the Agreement signed by ASH Plans and the Group.
- The services exceed the Maximum Benefit. This might occur if the Schedule of Benefits includes a maximum number of office visits. For example, if the Maximum Benefit provides coverage for a maximum number of office visits per year (e.g., 20) and you receive Covered Services beyond that limit, you must pay the provider for each office visit after reaching the limit (e.g., for each office visit after the 20th office visit). You should review the Schedule of Benefits, attached hereto as Appendix A, to determine the nature and extent of any applicable Maximum Benefit.

In situations such as those described above, ASH Plans will have no obligation to pay or reimburse you for those services.

ASH Plans distinguishes between "eligibility" for services and "approval" of services. "Eligibility" depends on an individual's status as a Member and the availability of Covered Services to you within any applicable Maximum Benefit. "Approval" relates to any required approval of Covered Services as Medically Necessary Services.

Maximum Benefit

You will be limited to a Maximum Benefit which is outlined in the Schedule of Benefits.

ASH Plans Payments

ASH Plans will pay each Contracted Provider directly. California law provides that each contract between ASH Plans and a Contracted Provider must provide that, if ASH Plans fails to pay the Contracted Provider, no Member shall be liable to the Contracted Provider for any sums owed by ASH Plans.

Your Liability

ASH Plans will cover only Acupuncture and Chiropractic Services that are Covered Services. Please note that the services listed in the "General Exclusions and Limitations" section of this Combined EOC are not covered. In addition, the exclusions and limitations for each kind of benefit are also listed in the Schedule of Benefits attached hereto as Appendix A.

ASH Plans reserves the right to change any provision of the Health Plan, including Covered Services, Health Plan Premiums and Copayments. Any changes shall be made in accordance with applicable state and federal laws.

If You Have More Than One Health Plan (Coordination of Benefits)

If you are covered by ASH Plans and another plan or contract providing chiropractic or acupuncture benefits or services, including Medicare, ASH Plans' benefits and services shall be coordinated with such other plan or contract in accordance with state and federal laws and regulations. You must inform ASH Plans if you are covered by any other

chiropractic or acupuncture benefit plan, including Medicare. If ASH Plans pays benefits in excess of those required under coordination of benefits laws and regulations, ASH Plans or a Contracted Provider may recover an excess payment from you or the other plan. ASH Plans may also reduce its coverage of you to avoid duplication of benefits available under Medicare. If you are eligible for Medicare coverage, but elect not to enroll in Medicare, you may have your benefits reduced as though you received Medicare benefits.

Determination of Medically Necessary Services

Under the oversight of the ASH Plans' Chief Medical Officer, ASH Plans' Vice President of Clinical Services and/or Director of Clinical Services, an ASH Plans' clinician in same or similar specialty as the provider of Acupuncture Services or Chiropractic Services under review will decide whether the Acupuncture Services or Chiropractic Services are or were Medically Necessary Services and therefore are or were Covered Services. ASH Plans uses clinical service evaluation procedures that it has developed for this purpose. ASH Plans will disclose to you, upon request, a description of ASH Plans' process to approve, modify or deny services based on Medical Necessity as well as ASH Plans' clinical criteria for specific procedures or conditions. Written requests may be mailed to:

American Specialty Health Plans of California, Inc.
Attention: Member Services
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans pays each Contracted Provider a negotiated fee for Covered Services provided to ASH Plans' Members. We do not specifically reward participating providers or other individuals for issuing denials of coverage or services. Utilization management decision making is based only on appropriateness of care and service and existence of coverage.

You may request additional information about these issues from ASH Plans or from a Contracted Provider. To request information from ASH Plans, please call 1 800-678-9133, visit our Web site at www.ashcompanies.com, or write to Member Services Department, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA , 92150-9002.

SEEING A DOCTOR AND OTHER PROVIDERS

ASH Plans has a network that includes chiropractors, acupuncturists and other health care providers. This chapter tells you about:

- Your choice of providers
- Getting a second opinion
- Continuity of care

Your Choice of Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Except as otherwise indicated in this Combined EOC, you must receive Covered Services from a Contracted Provider. You will have direct access to Contracted Providers without obtaining a physician referral. You may contact a Contracted Provider to schedule a new patient examination. After the new patient examination, all services require verification of Medical Necessity by ASH Plans in order to be Covered Services. For services received from a Contracted Provider, that Contracted Provider is responsible for obtaining verification of Medical Necessity from ASH Plans. Except as otherwise indicated in this Combined EOC, the Contracted Provider will be responsible for filing all claims with ASH Plans.

You may receive Covered Services from any Contracted Provider. Except for Emergency Services, Urgent Services, or in certain circumstances in counties in which there are no Contracted Providers, ASH Plans will not pay non-Contracted Providers for any services. A non-Contracted Provider is an acupuncturist or chiropractor who has not entered into an agreement with ASH Plans to provide Covered Services to you. Please note the following:

- You may receive Emergency Services or Urgent Services from any acupuncturist or chiropractor, including a non-Contracted Provider. ASH Plans will pay the non-Contracted Providers for the Emergency Services or Urgent Services to the extent they are Covered Services.
- If there are no Contracted Providers within 20 miles for urban/suburban areas or equivalent to 30 minute drive time, or within 45 miles for rural areas or equivalent to 60 minute drive time, of where you live or work ASH Plans will refer you to a non-Contracted Provider who is located within the applicable distance.
 - Where there are licensed providers, but no Contracted Providers within the distances referenced above, ASH Plans will pay the non-Contracted Provider for any services provided to you to the extent they are Covered Services.
 - Where there are no licensed acupuncturists or licensed chiropractors available within the distances referenced above, ASH Plans will refer you to the closest available Contracted Provider and you must receive services from a Contracted Provider in order for those services to be Covered Services.

Getting a Second Opinion

You may request a second opinion in regard to Covered Services by contacting another Contracted Provider. Your visit to another Contracted Provider for purposes of obtaining a second opinion generally will count as one visit, for purposes of any Maximum Benefit, and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other Contracted Provider.

A Contracted Provider may also request a second opinion in regard to Covered Services by referring you to another Contracted Provider in the same or similar specialty. When you are referred by a Contracted Provider to another Contracted Provider for a second

opinion, your visit to the other Contracted Provider will not count as a visit, for purposes of the annual Maximum Benefit.

Continuity of Care

If you are receiving Covered Services from a Contracted Provider at the time the Contracted Provider's contract terminates with ASH Plans, you may be able to continue to receive Covered Services from that provider for a limited period of time. In the case of Chiropractic Services, you must be receiving Covered Services for an acute condition, a serious chronic condition, or newborn child (birth to 36 months) at the time the provider's contract with ASH Plans terminates. In the case of Acupuncture Services, you must be receiving Covered Services for an acute condition, a serious chronic condition, newborn child care (birth to 36 months), a pregnancy, a terminal illness, or performance of a surgery or other procedure as authorized at the time the provider's contract with ASH Plans terminates. ASH Plans need allow you to continue to receive Covered Services from that provider if:

- 1) the Provider was terminated due to quality of care issues, board disciplinary actions, fraud or other criminal activity; or
- 2) the provider does not agree in writing to be subject to the same contract terms that existed prior to termination; or
- 3) the provider does not agree to develop a reasonable transition plan, in consultation with ASH Plans, for each Member in active treatment.

In addition, in the case of Chiropractic Services, if you are a newly enrolled Member and are receiving services for an acute condition, a serious chronic condition, or newborn child (birth to 36 months) when your coverage with ASH Plans becomes effective, you may be able to continue to receive Covered Services from that non-Contracted Provider for a limited period of time. In the case of Acupuncture Services, if you are a newly enrolled Member and are receiving services from a non-Contracted Provider for an acute condition, a serious chronic condition, newborn child care (birth to 36 months), a pregnancy, a terminal illness, or performance of a surgery or other procedure as authorized when your coverage with ASH Plans becomes effective, you may be able to continue to receive Covered Services from that non-Contracted Provider for a limited period of time. Your ability to receive continuity of care in the above mentioned situation will depend on a number of other factors, including whether the non-Contracted Provider agrees in writing to:

- 1) be subject to the same contractual terms and conditions that are imposed upon Contracted Providers, including, but not limited to, the compensation rates and methods of payment used by ASH Plans for Contracted Providers, clinical services management program, peer review, and quality assurance requirements; and

- 2) develop a reasonable transition plan, in consultation with ASH Plans, for each Member in active treatment.

ASH Plans only provides for continuity of care to the extent rendered services are Covered Services. You may obtain a copy of ASH Plans' Continuity of Care Policy via www.ashcompanies.com, or by contacting ASH Plans.

How to Request Continuity of Care

You must contact ASH Plans in writing or by telephone to request continuity of care. ASH Plans may be reached by calling 800-678-9133 or by writing to Member Services Department, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. You must provide the following information when contacting ASH Plans to request continuation of care: Member Name; Member ID; Member contact information; treating provider name and contact information; date of onset of current condition; description of current condition; and date of anticipated release from care for current condition.

YOUR BENEFITS

This chapter tells you about the health care benefits, also called services, that ASH Plans covers.

Chiropractic Services

For a detailed listing of Covered Services, you should review the applicable Schedule of Benefits attached hereto as Appendix A. Please note that the amount of Covered Services will be limited based on the Schedule of Benefits chosen by your Group. Generally, however, the following are Covered Services:

- New Patient Examination
- Established Patient Examination
- Follow Up Office Visits
- Adjunctive modalities and procedures
- X-rays and clinical laboratory tests
- Chiropractic Supports and Appliances

All Chiropractic Services except for the initial evaluation must be verified by ASH Plans as Medically Necessary for treatment of either Neuromusculoskeletal Disorders and/or Pain Syndromes in order to be Covered Services.

Acupuncture Services

For a detailed listing of Covered Services, you should review the applicable Schedule of Benefits attached as Appendix A. Please note that the amount of Covered Services will be limited based on the Schedule of Benefits chosen by your Group. Generally, however, the following are Covered Services:

- New Patient Examination
- Established Patient Examination
- Follow-up Office Visits

- Adjunctive Therapies and Modalities

All Acupuncture Services except for the initial evaluation must be verified by ASH Plans as Medically Necessary for treatment of Neuromusculoskeletal Disorders, Nausea and/or Pain in order to be Covered Services.

Emergency Care

If you believe that you require medical services in an emergency, ASH Plans recommends that you consider contacting your primary care physician or another physician or call “911”. You are encouraged to use appropriately the “911” emergency response system, in areas where the system is established and operating, when you have an emergency medical condition that requires an emergency response.

Because ASH Plans arranges only Acupuncture and Chiropractic Services, ASH Plans only covers Emergency Services to the extent they comprise Emergency Acupuncture Services or Emergency Chiropractic Services.

ASH Plans will not cover any services as Emergency Services unless the provider rendering such services can show that the services in fact were Emergency Services.

Urgent Care

Because ASH Plans arranges only Acupuncture and Chiropractic Services, ASH Plans only covers Urgent Services to the extent they comprise Urgent Acupuncture Services or Urgent Chiropractic Services.

ASH Plans will not cover any services as Urgent Services unless the provider rendering such services can show that the services in fact were Urgent Services.

Experimental and Investigational Treatments

An experimental or investigational treatment is care that is (a) investigatory; or (b) an unproven service that does not meet generally accepted and professionally recognized standards of practice.

- In general, ASH Plans does not cover experimental or investigational treatments. If you request a treatment and ASH Plans decides that the treatment is experimental or investigational, we will send you a denial letter within 5 days of your request.
- However, you may have the right to an Independent Medical Review (IMR) of ASH Plans’ denial. If the review is decided in your favor, ASH Plans must cover the treatment approved by the IMR.
 - The treatment must be for a life-threatening or seriously debilitating condition.
 - You do not have to file a complaint with ASH Plans before you apply for an IMR.
 - The California Department of Managed Health Care (DMHC) oversees the IMR.

- The IMR takes 30 days from the time DMHC receives your application and supporting documentation.
- If your need for the treatment is urgent, ask DMHC for an expedited review. The IMR will take up to 7 days.
- To apply for an IMR contact the Department of Managed Health Care:
 - Call: 1-888-HMO-2219 (1-888-466-2219)
 - Staff are available 24-hours-a-day, every day, and can help you in many languages.
 - There is no charge to call.
 - Go to: www.hmohelp.ca.gov. The Web site has Independent Medical Review and complaint forms and instructions.

GENERAL EXCLUSIONS AND LIMITATIONS

This chapter tells you about the exclusions and limitations of your Health Plan. Exclusions and limitations are services and expenses that ASH Plans does NOT cover. The exclusions and limitations for each kind of benefit are also listed under the Schedule of Benefits attached hereto as Appendix A.

ASH Plans will not cover:

- Care you get from a doctor who is not in the ASH Plans network, unless you have pre-approval from ASH Plans, or you need Emergency Services, or you are outside the ASH Plans Service Area and need Urgent Services.
- Care that is not Medically Necessary.
- Services that are ordered for you by a court, unless they are Medically Necessary and covered by ASH Plans.
- The cost of copying your medical records. (This cost is usually a small fee per page).
- Expenses for travel, such as taxis and bus fare, to see a provider or get health care.
- Experimental and Investigational Treatments.

ENROLLING IN ASH PLANS AND ADDING DEPENDENTS

Your ASH Plans coverage is a group health plan you get through your Group.

This chapter tells you about:

- When you can join ASH Plans
- Who can be on your health plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join ASH Plans
- Enrollment in ASH Plans
- Renewal Provisions

When You Can Join ASH Plans

You and your family members may enroll in ASH Plans if you and your family members meet the eligibility requirements of the Group and reside within the Service Area. You or your family member should contact your Group regarding eligibility for ASH Plans.

Who Can Be On Your Health Plan (who can be your dependent)

You can enroll the following family members on your health plan. They are called your dependents. Talk to your Group to find out how much it costs to add dependents to your health plan.

- Your Spouse
- Your Domestic Partner.
- Unmarried Children: your own or those of your spouse or Domestic Partner
 - The children must be under the age of [19]. They may be your natural children, legally adopted children, or stepchildren.
 - Children can be covered up to age [24] if they are full-time students at an accredited college, university, trade school, or professional school.
 - A disabled child can be covered past age [19] if the child is unable to work, because of a physically or mentally disabling injury, illness or condition. You must be the main source of support and maintenance of the child.
 - At least 90 days before coverage will end for a disabled child, ASH Plans will send you a written notice. You must show proof of disability and support within 60 days after you receive this notice. ASH Plans will tell you if the child can continue to be covered. You may be asked to show proof again once a year, starting two years after the child reaches the age of [24].
 - ASH Plans may also request proof if you are enrolling a disabled child for new coverage. You must provide the requested information within 60 days of the request. The child must have been covered as a dependent of you or your spouse under a previous health plan at the time the child reached age [19]. You may be asked to show proof again no more than once a year.

Adding New Dependents

You can add the following new dependents any time during the year:

- A spouse. If you marry, you can put your spouse on your health plan.
 - ASH Plans must receive a completed enrollment form within 30 days of the date of your marriage.

- Ask your Group when benefits for your spouse will begin. It will be either on the date of your marriage or the first day of the month following the date ASH Plans receives the completed enrollment form.
- A Domestic Partner
 - ASH Plans must receive a completed enrollment form within 30 days of the date you file a Declaration of Domestic Partnership with the Secretary of State, or within 30 days after you form the partnership according to your Group's rules.
 - Ask your Group when benefits for your Domestic Partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date ASH Plans receives the completed enrollment form.
- A newborn child
 - To keep your newborn on your health plan, ASH Plans must receive a completed enrollment form within 30 days after the birth.
 - If you miss the deadline, your newborn will not have health benefits after the first 30 days.
- An adopted child
 - To keep your adopted child on your health plan, ASH Plans must receive a completed enrollment form within 30 days after the adoption.
 - If you miss the deadline, a newborn adopted child will not have health benefits after the first 30 days.
- A stepchild. You may put a child of your spouse or Domestic Partner on your health plan.
 - You must complete an enrollment form and send it to ASH Plans within 30 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
 - Ask your Group when benefits for your stepchild will begin. It is either on the date of your marriage or domestic partnership or the first day of the month following the date ASH Plans receives the completed enrollment form.

Special Times You and Your Dependents Can Join ASH Plans

You can enroll in ASH Plans in these situations when:

- ASH Plans cannot produce a form showing that you declined enrollment because you had other health care coverage.
- You did not previously enroll in ASH Plans because:
 - You had continuation of coverage benefits, and now that coverage has ended.
 - You had Healthy Families or Medi-cal with no share-of-cost, and now you no longer qualify for it.

- You were covered by another group health plan, and now that coverage has ended.
- When a court orders that you cover a current spouse or minor child on your health plan

How to apply at these additional times:

- ASH Plans must receive a completed enrollment form from you within 30 days of that date on which you no longer have coverage.
- Your coverage will be in effect the first day of the month following receipt of the completed enrollment application.

Enrollment in ASH Plans

You or your dependent must enroll in ASH Plans through your Group. Most Groups have an established open enrollment period when eligible individuals may enroll in ASH Plans.

Your Group will notify you and your Dependents when coverage under the Health Plan begins.

Renewal Provisions

The health plan contract entered into by ASH Plans and the Group sets forth your rights and benefits. That contract will automatically renew unless terminated by ASH Plans or the Group. You should contact your Group with questions regarding the renewal or termination of that contract. At the time of renewal, ASH Plans has the right to change the Health Plan Premiums or any other provision of that contract, as allowed by applicable state and federal laws.

WHEN YOUR ASH PLANS HEALTH COVERAGE ENDS

[TERMINATION OF BENEFITS]

Your health coverage with ASH Plans can end for several reasons. If this happens, you may be able to continue your health coverage. See the section entitled “Continuing Health Coverage” for more information.

This chapter tells you about:

- Why your health coverage can end
- Reinstatement of benefits
- What to do, if you think ASH Plans should not have ended (terminated) your benefits
- When a dependent no longer qualifies as a dependent

Why Your ASH Plans Health Coverage Can End

ASH Plans cannot end your health benefits because of your health needs or medical condition. But ASH Plans can end (terminate) your health coverage for one of the reasons below.

- Your Group voluntarily terminates the Agreement. Membership will terminate at the end of the month for which the last Health Plan Premium is received by ASH Plans on your behalf.
- ASH Plans does not receive the applicable Health Plan Premium for you within thirty (30) days after Group receives a notice of termination for non-payment from ASH Plans, provided that the notice shall state that receipt by ASH Plans of the applicable Health Plan Premium within that thirty (30) day period shall cause ASH Plans to revoke the notice. Except as otherwise provided in the immediately preceding sentence, termination shall take effect at the end of that thirty (30) day period.
- You no longer live or work in the Service Area. This does not apply to a Dependent child who is a full-time student and who is absent from the Service Area to attend school. Termination shall be effective on the last day of the month in which you receive a termination notice from ASH Plans.
- Your eligibility ceases. Subject to the provisions set forth below under “Individual Continuation of Health Coverage”, termination shall be effective on the last day of the month in which your eligibility ceases.
- Fraud or deception by you in the use of the services or facilities of ASH Plans or you knowingly permitting such fraud or deception by someone else. Termination shall take effect on the day after you receive a written notice of termination from ASH Plans.
- If your behavior is of a violent or seriously abusive nature that may seriously threaten or jeopardize the safety of ASH Plans, any employee or agent of ASH Plans, any Contracted Provider, or any employee, agent, or patient of a Contracted Provider. Termination shall take effect on the day after you receive a written notice of termination from ASH Plans.

In all of the circumstances described above, termination of benefits shall apply to all benefits, including benefits for a Member who is hospitalized or undergoing treatment for an ongoing condition, to the extent the Member receives those benefits after the effective date of the termination.

Reinstatement of Benefits

You may re-enroll in ASH Plans if your coverage has terminated and you are eligible for re-enrollment through a Group. You must, however, submit a new enrollment application to ASH Plans during an open enrollment period.

If You Think ASH Plans Should NOT Have Ended (terminated) Your Benefits:

ASH Plans cannot end your health benefits because of your health needs or medical condition.

If you think that ASH Plans wrongly ended your benefits, you can file a complaint with the Department of Managed Health Care at 1-888-HMO-2219.

When a Dependent No Longer Qualifies As a Dependent

You must tell ASH Plans and your employer as soon as a family member no longer qualifies as a dependent on your health plan. Family members may no longer qualify as dependents in the following situations:

- You and your spouse get a divorce or a legal separation.
- You legally end your domestic partnership.
- Your children stop qualifying as your dependents.
 - When they turn [19], or [24] if they are full-time students.
 - When they marry.
 - When they are [19] or older and no longer have a physical or mental handicap that prevents them from working, or you are no longer supporting them.

INDIVIDUAL CONTINUATION OF HEALTH COVERAGE

U.S. and California laws protect your right and your dependents' right to continue your health coverage under certain circumstances or qualifying events. This is called continuation health coverage or continuation of benefits.

California law requires that we include the following statement about continuation health coverage:

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

This chapter tells you about:

- Understanding your choices
- COBRA

Understanding Your Choices

Look at all of your choices carefully before you decide what to do.

- You may be able to buy continuation coverage of your health benefits with your Group. You cannot be denied continuation coverage because of your medical history.

or

- You can buy an individual health insurance on your own. If you do this, the insurance company usually reviews your medical history. You may be charged a higher premium or you may be denied health benefits entirely if you have a medical condition now or are likely to develop one.

or

- You can decide not to buy any health coverage. In this case, you will have to pay all of the cost of any health care you need. This can be thousands of dollars.

If you choose continuation health coverage

- You have to pay all the premiums.
- You cannot be refused coverage because of your medical history.
- After you use up one kind of continuation coverage, you may be eligible for another kind.
- There are deadlines and other requirements that you have to meet to buy continuation coverage. Call your Group for more information.

COBRA

For more information on COBRA, call the Federal Employee Benefits Security Administration (EBSA), toll-free, at 1-866-444-3272.

- COBRA is a U.S. law that applies to employers who have 20 or more employees in their group health plan.
- COBRA may allow you and your dependents to keep medical coverage for up to 18 or 36 months, depending on the qualifying event and other circumstances.
- Each qualified person may independently elect/enroll in COBRA coverage. A parent or legal guardian may elect COBRA for a minor child.
- With COBRA, you have the same benefits as current employees of your Group
- You have to pay all of the monthly premium.

Important deadlines for electing/enrolling in COBRA with ASH Plans:

It is important to meet the following deadlines. If you do not, you lose your right to COBRA coverage.

1. Notification of qualifying event:

- Employers must notify your Group within 30 days after the following qualifying events:
 - The employee's job ends
 - The employee's hours of employment are reduced
 - The employee becomes eligible to receive Medicare benefits
 - The employee dies
- You or your dependent must notify your Group in writing within 60 days after any of the following qualifying events:
 - The employee divorces or legally separates
 - A child or other dependent no longer qualifies as a dependent under plan rules

2. Election notice: Generally, you must be sent an election notice not later than 14 days after your Group receives notice that a qualifying event has occurred.

3. Election period: You have 60 days to notify your Group in writing that you want to elect/enroll in COBRA coverage. The 60 days starts on the later of the following two dates:

- The date you receive the election notice.
- The date your coverage ended.

4. Premium payment: You must pay the premiums for your COBRA coverage. Your Group must receive your first premium within 45 days after you enroll in COBRA. This first premium covers the time from the date your coverage ended because of the qualifying event up to the day you signed up for COBRA. You must then pay a monthly premium as long as you stay on COBRA.

You will lose COBRA if:

- You do not pay your premiums on time.
- You move outside the ASH Plans service area.
- Your former employer no longer offers any health plan.
- You become eligible for Medicare.
- You sign up for another health plan. (However, if your new plan has a waiting period for pre-existing conditions and you have not used up all of your COBRA, you can keep COBRA until the waiting period is over.)
- You commit fraud, which means that you intentionally deceive ASH Plans or you misrepresent yourself or allow someone else to do so in order to get health care services.

Upon request by a Group, ASH Plans shall make available continuation coverage under the Health Plan to Members entitled to continuation coverage based upon the

requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), as amended.

IF YOU HAVE A PROBLEM WITH ASH PLANS

ASH Plans is committed to meeting the needs of our members. Our Member Services staff is available to answer questions and help you get the health care you need. If you have a problem with ASH Plans, you have the right to file a complaint. A complaint is also called a grievance or an appeal.

This section tells you what you can do if you have a complaint with ASH Plans:

- File a complaint with ASH Plans
- ASH Plans Appeals and Grievances Procedures
- If You Still Need Help, Contact the Department of Managed Health Care
- Independent Medical Review (IMR)
- Voluntary Arbitration
- Member Claims Against Contracted Providers

File a Complaint with ASH Plans

If you have a concern or complaint regarding the services you have received from ASH Plans or a Contracted Provider, you should call ASH Plans at 1-800-678-9133. Working through a Member Services Representative will enable you to resolve most issues quickly and satisfactorily. If you feel that the issue has not been resolved after speaking with a Member Services Representative, you may submit an Appeal or Grievance to ASH Plans. The Appeal or Grievance may be submitted verbally by calling ASH Plans’ Member Services department at 1-800-678-9133, online via ASH Plans’ Web site at www.ashcompanies.com, or by mail at the following address:

American Specialty Health Plans of California, Inc.
Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans Member Services Department is ready to assist you with filing an Appeal or Grievance through ASH Plans Appeal and Grievance Procedure as described below. Such assistance includes helping you write the Appeal or Grievance.

You may obtain a Member grievance form and a description of ASH Plans Grievance Procedure from any Contracted Provider, ASH Plans or on the ASH Plans’ Web site (www.ashcompanies.com).

ASH Plans Appeal and Grievance Procedures

You may file an Appeal or Grievance within one hundred eighty (180) days of any incident or action that results in dissatisfaction to you. ASH Plans will work with you to resolve the Appeal or Grievance.

ASH Plans will provide you with written acknowledgement of receipt of an Appeal or Grievance within five (5) calendar days of receipt. The written acknowledgement will include the date of receipt by ASH Plans and will provide you with the name, address and telephone number of the ASH Plans representative handling the Appeal or Grievance. The acknowledgement letter will also include the Department of Managed Health Care's toll-free telephone number, the Department of Managed Health Care's TDD line for the hearing and speech impaired, ASH Plans' telephone number and the Department of Managed Health Care's internet address.

ASH Plans will send a resolution letter to you within thirty (30) calendar days of receipt of an Appeal or Grievance. The resolution letter will give a clear, concise explanation of the reasons for the determination and will define your additional rights.

If an Appeal or Grievance involves an imminent and serious threat to your health — including, but not limited to, severe pain, potential loss of life, limb, or major bodily function—ASH Plans will evaluate and resolve the Appeal or Grievance on an expedited basis and will send you a written statement that sets forth such resolution within three (3) days from receipt of the clinical Appeal or Grievance.

ASH Plans will not send a written acknowledgement letter and a resolution letter when Appeals or Grievances are received by telephone and are not coverage disputes, disputes involving Medical Necessity, or Experimental or Investigational treatment and are resolved by the next business day following receipt.

If you are not satisfied with the determination of an Appeal or Grievance, that involves a coverage dispute, you may file such Appeal or Grievance with the Department of Managed Health Care. For an Appeal or Grievance that involves a denial due in whole or part to Medical Necessity, you may apply for Independent Medical Review through the Department of Managed Health Care. You also have the option to initiate arbitration through the National Arbitration Forum (“the Forum”). At any time after completion of ASH Plans Grievance Procedure process outlined above, you may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act.

Assistance for Members with Special Needs

ASH Plans Grievance Procedure ensures that all Members have access to and can fully participate in the grievance system by providing assistance to those with limited English proficiency or with a visual or other communicative impairment. ASH Plans maintains a toll-free telephone number answered by Member Services Representatives who are trained to provide assistance with translations of grievance procedures, forms and ASH Plans' responses to Appeals or Grievances.

If You Still Need Help, Contact the Department of Managed Health Care

You may submit an Appeal or Grievance to the Department of Managed Health Care for evaluation after you have participated in ASH Plans' appeals and grievance process for at least thirty (30) days. If your Appeal or Grievance involves an imminent and serious threat to your health—including, but not limited to, severe pain, potential loss of life, limb, or major bodily functions—you may submit the grievance to the Department of Managed Health Care without waiting thirty (30) days. The Department of Managed

Health Care shall be the final arbiter when there is a question as to whether a dispute over a health care service is eligible for Independent Medical Review, and whether extraordinary and compelling circumstances exist that waive the requirement that the Member first participate in the plan's grievance system.

Your rights related to filing a complaint with the Department of Managed Health Care are set forth in the following statement:

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number (1-888-HMO-2219) and a TDD line for the speech and hearing impaired (1-877-688-9891) to receive complaints regarding health plans. The Department's internet website (<http://www.hmoHELP.ca.gov>) has complaint forms, IMR application forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at 1-800-678-9133 and use the plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

Independent Medical Review

If ASH Plans denies coverage for Experimental or Investigational services or denies, delays or modifies services or treatment based on a decision that, in whole or in part, the care is not Medically Necessary, ASH Plans will notify you in writing of the opportunity to request an Independent Medical Review (IMR) of the decision to deny coverage. The notification will include, at a minimum, information on the IMR process, an IMR application and envelope addressed to the Department of Managed Health Care, the physician certification form (when applicable) and the Department of Managed Health Care's toll-free information number.

Your application for an IMR shall include:

- A copy of ASH Plans' or Contracted Provider's determination and any relevant material or documentation that you wish to provide.
- If expedited review is requested for a decision eligible for IMR based on Medical Necessity, the application shall include a certification from your physician or provider indicating that an imminent and serious threat to your health exists.
- Reviews requested for a decision eligible for IMR based on Experimental or Investigational therapies, require a certification from your treating physician or provider. The physician's certification shall be on a Department of Managed Health Care issued form, or contain the following information:

1. The Member has a condition as defined in H&S Code Section 1370.4(a)(1). Every health care service plan shall provide an external, independent review process to examine the plan's coverage decisions regarding experimental or investigational therapies for Members who meet all of the following criteria:

The Member has a life-threatening or seriously debilitating condition. For purposes of this section, "life-threatening" means either or both of the following:

- (i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- (ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

- 2. Background information including the name of the Member and the health plan; the physician's name, specialty, board certification, if applicable, address, telephone, and fax number; whether the physician is contracted with ASH Plans, the Member's medical condition; and the specific drug, device, procedure, or other therapy recommended or requested for the Member's medical condition.
- 3. For non-Contracted Providers, the certification shall also include the following: (a) The physician's license, board-certification or board eligibility to practice in the area appropriate to treat the Member's condition; and, (b) Reference to, or copies of, two documents from medical or scientific literature, specified in section 1370.4(d) of the Act (Published peer-reviewed scientific studies, literature, and medical journals recognized by the Secretary of Health and Human Services).
- 4. The following statement and physician signature: I certify that the requested therapy is likely to be more beneficial than any standard therapy. The information provided herein is true and correct.
- 5. Where expedited review is requested the certification shall include a statement that imminent and serious threat to the health of the enrollee exists or the proposed therapy would be significantly less effective if not promptly initiated.
- 6. Attachments, including any additional references or copies of medical and/or scientific literature considered relevant to the requested therapy and any other information relevant to the request.

Voluntary Arbitration

If a Member is dissatisfied with the resolution of an Appeal or Grievance, and the Member seeks to arbitrate a dispute, the Member must give notice to ASH Plans. The notice must contain a demand for arbitration and must describe the dispute, the issues involved, the amount of any claim, and the remedy sought.

The Member and ASH Plans will follow applicable law with regard to arbitration and ASH Plans' arbitration policies. California law may require, for a dispute involving

\$200,000 or less, that the Member and ASH Plans select a single, neutral arbitrator. In that situation, the arbitrator will not have the power to award more than \$200,000.

At a Member's request, ASH Plans will send the Member a copy of ASH Plans' arbitration policies. Those policies, as ASH Plans may amend them from time to time, will bind the Member and ASH Plans.

The arbitration process will be held in accordance with the National Arbitration Forum Bill of Rights requirements of fair and appropriate procedures and remedies and must be submitted to the Forum in accordance with those procedures. Any arbitration under the Agreement will be held in California at a location mutually acceptable to the parties, provided that, if the parties cannot agree on a location for the arbitration, the Forum shall specify the location. In cases of extreme hardship, ASH Plans will pay all or a part of a Member's fees and expenses for a neutral arbitrator.

Member Claims Against Contracted Providers

Contracted Providers are independent contractors, and ASH Plans has no responsibility for the acts, or failure to act, of a Contracted Provider. ASH Plans is not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving Chiropractic or Acupuncture Services from a Contracted Provider.

Members with claims for damages because of an injury caused or alleged to have been caused by an act, or failure to act, of a Contracted Provider, can seek any action against such persons and entities deemed appropriate in accord with California law.

QUALITY IMPROVEMENT PROGRAM

ASH Plans has an active quality improvement (QI) program that is designed to improve the quality of clinical care and service provided to Members. ASH Plans' commitment to quality, innovation, teamwork, and effective training has contributed to its success in effectively meeting the health care needs of its Members. ASH Plans' QI program is directed by the Corporate Quality Oversight Committee. The committee evaluates the QI program annually. To access the American Specialty Health Annual QI Evaluation Executive Summary, please visit www.ashcompanies.com. Click on Member/Insured and either enter your log-in information or select "ASH Plans of California." From this page, you will be able to access the Executive Summary by clicking on "Quality Improvement" on the left side of the page.

YOUR RIGHTS AND RESPONSIBILITIES AS A MEMBER OF ASH PLANS

As a member of ASH Plans you have rights and responsibilities. Each member has the same rights and responsibilities.

Your Rights

You have a right to:

- Considerate and respectful care;
- Receive information about our organization, our services, our practitioners and providers and your rights and responsibilities;
- Receive information about your illness in understandable terms so that you may give informed consent (except in emergencies, this information should include the proposed course of treatment, alternatives, possibilities of non-treatment, prospects for recovery, and clinical risks involved);
- Use the information you have received to participate – to the extent permitted by law in decisions regarding care, including the right to refuse treatment;
- Full consideration of privacy, including case discussion, consultation, examination and treatment, all of which are confidential and should be conducted discreetly, with your consent to the presence of any third parties;
- Reasonable continuity of care and advance notification of the appointment time and location as well as the identity of the person(s) providing care;
- Be advised of and refuse treatment if your health care provider engages in experimental studies/procedures affecting your care or treatment;
- Be informed of continuing health care requirements following discharge from treatment;
- Receive Medically Necessary and appropriate care and services, as defined in your member benefit plan;
- File complaints and grievances when dissatisfied with the treatment or service you have received;
- Request and receive any available information about health education, promotion, and prevention services; community services that may help to assist with your health problems; and the appropriate use of treatments, regardless of your relationship your health care benefits;
- Right to candid discussion of appropriate or medically necessary treatment option for your condition, regardless of cost or benefit coverage;
- Examine and receive an explanation regarding any charges billed to you;
- Have these rights apply to the person who has legal responsibility for making decisions regarding your medical care;
- Exercise these rights without regard to gender; ethnic, cultural, economic, educational, or religious background; or the source of payment for care;
- Obtain free interpretation services in your preferred language when communicating with our organization or our practitioners;
- Request and receive translation of vital documents in threshold languages, where applicable; and

- Make recommendations regarding our members' right and responsibilities policies.

You have the right to have a copy of your medical records:

- It takes a few days to get the copy, and you may be charged for the copying.
- To get a copy of your medical records, call your provider's office or call ASH Plans at 1-800-678-9133

You have the right to keep your medical records private:

A statement describing ASH Plans' policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

To request a copy, call ASH Plans' Member Services at 1-800-678-9133.

You have the right to take part in making ASH Plans' public policy:

ASH Plans has established a Public Policy Committee to make recommendations regarding ASH Plans' public policy. For information about participation in this committee or to request additional information regarding the development of ASH Plans' public policies, please call ASH Plans at 1-800-678-9133.

Your Responsibilities

It is your responsibility to:

- Give your health care provider and/or health plan the information necessary to provide you with the best possible care;
- Follow the treatment plan and instructions for care upon which you and your health care provider have agreed; and
- Promptly pay Copayment amounts.

USEFUL TERMS

The following is a list of some terms used in this Combined EOC. Additional terms related to specific benefits are defined in the Schedule of Benefits.

Agreement means the agreement ASH Plans signed with a Group under which Members are entitled to receive Covered Services.

Appeal means a formal written or verbal request by a Member for reconsideration of an adverse determination, such as coverage disputes and Medical Necessity disputes.

Clinical Services Management Program defines the process for monitoring and evaluation of treatment/services provided to Members by Contracted Providers. The Clinical Services Management Program provides a structured approach to verify the Medical Necessity and appropriateness of treatments/services delivered to Members through the data submitted on clinical treatment forms.

Combined EOC means this Acupuncture and Chiropractic Benefit Combined Evidence of Coverage and Disclosure Form, including the Schedule of Benefits attached to and incorporated by reference into this Combined EOC.

Covered Services are the Medically Necessary services which are set forth in Appendix A, Schedule of Benefits and which are covered under the applicable Health Plan. Covered Services are subject to copayments and annual benefit limits or visit limits set forth in the Schedule of Benefits attached hereto as Appendix A of this Combined EOC.

Dependent is any spouse, Domestic Partner or unmarried child (including step-child or adopted child) of Subscriber.

Domestic Partner is a person with whom you have established a domestic partnership by a valid declaration of domestic partnership filed with the California Secretary of State, or otherwise recognized as valid legal union formed in a jurisdiction outside California, pursuant to Division 2.5 of the California Family Code.

Grievance is a formal written or verbal expression of dissatisfaction initiated by the Member, such as quality of care, quality of service and access to care. A complaint is considered a grievance.

Grievance Procedures are ASH Plans' procedures for evaluating Member complaints, grievances and appeals.

Group is the employer, labor union trust, association or other entity which contracts with ASH Plans for the provision of Covered Services to Members.

Health Plan is the health plan contract offered by ASH Plans and described in this brochure.

Medicare is the health benefit program provided under Title VIII of the Social Security Act as amended and administered by the Centers for Medicare and Medicaid Services.

Member is a Subscriber or Dependent (a) who meets the eligibility requirements of Group; (b) who is enrolled with Group under a benefit plan that includes the Covered

Services described in this Combined EOC; and (c) for whom ASH Plans has received the applicable Premiums.

Member Services Department is the person or persons designated by ASH Plans to whom oral and written Member questions, concerns or complaints may be addressed. The Member Services Department may be contacted by telephone at 1-800-678-9133 or by writing to the Member Services Department at:

American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

Schedule of Benefits is the schedule of Covered Services available to a Member under the Health Plan that is attached to and incorporated by reference into this Combined EOC.

Service Area is the geographic area in which ASH Plans is licensed to provide or arrange Chiropractic or Acupuncture Services in the State of California by the California Department of Managed Health Care.

Subscriber is the person whose employment or other status, except for family dependency, is the basis for eligibility for membership under the Health Plan.

APPENDIX A: SCHEDULE OF BENEFITS

CHIROPRACTIC & ACUPUNCTURE COVERAGE

BENEFIT PLAN

PLAN: CAP06

No Deductibles;

\$10 Copayment Per Visit

30 Visit Annual Maximum

Benefits include Chiropractic Services and Acupuncture Services that are Medically Necessary Services provided by a Contracted Provider. In case of Acupuncture Services, the services must be for treatment and diagnosis of Neuromusculoskeletal Disorders, Nausea and Pain. In case of Chiropractic Services, the services must be for treatment of either Neuromusculoskeletal Disorders or Pain Syndromes or both.

CALCULATION OF ANNUAL MAXIMUM BENEFIT LIMITS

Each visit to a Contracted Provider, as described below, requires a Copayment by the Member. A maximum number of visits to either a Contracted Chiropractor or a Contracted Acupuncturist, or any combination of both, per calendar year will apply to each Member.

Chiropractic Services: Adjunctive therapy is allowed at each office visit, if approved by ASH Plans. If adjunctive therapy is provided without an adjustment, the adjunctive therapy will count as an office visit towards the Maximum Benefit. If an examination or re-examination is supplied without an adjustment, the examination or re-examination will count as an office visit towards the Maximum Benefit.

Acupuncture Services: Adjunctive therapy is allowed at each office visit, if approved by ASH Plans. If adjunctive therapy is provided without acupuncture treatment, the adjunctive therapy will count as an office visit towards the Maximum Benefit. If an examination or re-examination is supplied without acupuncture treatment, the examination or re-examination will count as an office visit towards the Maximum Benefit.

PROVIDER ELIGIBILITY

ASH Plans only contracts with duly licensed California chiropractors, acupuncturists, chiropractic radiologists, radiology groups, clinical laboratory groups, medical radiologists, medical pathologists and hospitals. Members must use Contracted Providers.

DEFINITIONS

Acupuncture Services are services rendered or made available to a Member by a Contracted Acupuncturist (or in case of Emergency Services or Urgent Services by a non-Contracted Acupuncturist) for treatment or diagnosis of Neuromusculoskeletal Disorders, Nausea, and Pain. Acupuncture means the stimulation of a certain point on or near the surface of the body by the insertion and removal of single-use, sterilized, disposable needles and/or electrical stimulation (electro-Acupuncture) to normalize physiological functions, to prevent or modify the perception of Pain or to treat Neuromusculoskeletal Disorders, Nausea, or conditions which include Pain as a primary symptom. In addition, it may include such services as adjunctive physiotherapy modalities and procedures provided during the same Course of Treatment and in support of Acupuncture Services.

Chiropractic Services are the chiropractic manipulation services provided by a Contracted Chiropractor (or in case of Emergency Services or Urgent Services, by a non-Contracted Chiropractor) for treatment or diagnosis of Neuromusculoskeletal Disorders and Pain Syndromes. These services are limited to the management of Neuromusculoskeletal Disorders and Pain Syndromes primarily through chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. This includes: 1) differential diagnostic examinations and related diagnostic X-rays, radiological consultations, and clinical laboratory studies when used to determine the appropriateness of Chiropractic Services; 2) the follow-up office visits which must include during the Course of Treatment the provision of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. In addition, it may include such services as adjunctive physiotherapy modalities and procedures provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

Contracted Acupuncturist is an acupuncturist who is duly licensed to practice acupuncture in the state of California and who has entered into an agreement with ASH Plans to provide Covered Services to Members.

Contracted Chiropractor is a chiropractor who is duly licensed to practice chiropractic in the State of California and who has entered into an agreement with ASH Plans to provide Covered Services to Members.

Contracted Provider is a Contracted Chiropractor, Contracted Acupuncturist or other licensed health care provider under contract with ASH Plans for the purpose of rendering Covered Services to Members, as appropriate.

Course of Treatment is a sequence or series of office visits directly related to a diagnosed disease state, illness, or injury and provided in conjunction with a defined clinical outcome.

Emergency Services consist of Covered Services that are Acupuncture Services or Chiropractic Services provided to manage an injury or condition with a sudden and unexpected onset, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health or medicine, could reasonably expect that the absence of immediate clinical attention to result in (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; (3) serious dysfunction of any bodily organ or part; or (4) decreasing the likelihood of maximum recovery. ASH Plans shall determine whether Acupuncture or Chiropractic Services constitute “Emergency Acupuncture Services” or “Emergency Chiropractic Services”. ASH Plans’ determination shall be subject to ASH Plans’ Grievance Procedures and the Department of Managed Health Care’s independent medical review process.

Maximum Benefit is the maximum amount which ASH Plans will pay for Covered Services provided on an annual basis to a Member by Contracted Providers.

Medically Necessary Services. “Medically Necessary” or “Medical Necessity” shall mean health care services that a healthcare provider, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the patient’s illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

For the purposes of the definition of “Medically Necessary Services” above:

“Prudent Clinical Judgment” are those (a) clinical decisions made on behalf of a patient by a provider in a manner which result in the rendering of necessary, safe, effective, appropriate clinical services; (b) clinical decisions that result in the appropriate clinical intervention considering the severity and complexity of symptoms; (c) decisions that result in the rendering of clinical interventions consistent with the diagnosis and are appropriate for the member’s response to the clinical intervention; (d) decisions rendered in accordance with the provider’s professional scope of license or scope of practice regulations and statutes in the state where the provider practices.

“Generally Accepted Standards of Medical Practice” means standards that are based on Credible Scientific Evidence published in peer-reviewed Medical Literature generally recognized by the relevant medical community, Physician and Healthcare Provider Specialty Society recommendations, the views of physicians and healthcare providers practicing in relevant clinical areas, and any other relevant factors.

“Credible Scientific Evidence” is clinically relevant scientific information used to inform the diagnosis or treatment of a patient that; meets industry standard research quality criteria, is adopted as credible by an ASH Plans clinical peer review committee; and has been published in an acceptable peer-reviewed clinical science resource.

“Medical Literature” means clinically relevant scientific information published in an acceptable peer-reviewed clinical science resource.

Clinical services that are “Considered Effective” are those diagnostic procedures, services, protocols, or procedures that are verified by ASH Plans as being

rendered for the purpose of reaching a defined and appropriate functional outcome or Maximum Therapeutic Benefit; and rendered in a manner that appropriately assesses and manages the member's response to the clinical intervention.

“Convenience of the Patient or Healthcare Provider” means considered to be an elective service. Examples of elective/convenience services include: (a) preventive maintenance services; (b) wellness services; (c) services not necessary to return the patient to pre-illness/pre-injury functional status and level of activity; (d) services provided after the patient has reached Maximum Therapeutic Benefit.

“Maximum Therapeutic Benefit” is the patient's health status when returned to pre-clinical/pre-illness daily functional activity and/or the patient's health status when the patient no longer demonstrates progressive improvement toward return to pre-clinical/pre-illness daily functional activity.

A “Healthcare Provider Specialty Society” is a society of specialty providers that represents a significant number of practicing practitioners or other academic or clinical research institutions for that specialty.

Musculoskeletal Functional Disorders are disorders that are abnormal functions and/or activities-of-daily-living limitations of the body resulting from muscle stiffness, muscle restriction, and/or range of motion limitations.

Myofascial Disorders are conditions with associated signs and symptoms related to the muscular and related systems. Myofascial Disorders are conditions typically categorized as structural, spasms or inflammatory disorders or dysfunction of the muscles of the body.

Myofascial/Musculoskeletal Disorders are conditions with signs and symptoms that relate to the muscular and related systems. Myofascial/Musculoskeletal Disorders are conditions typically categorized as: structural; spasms; or inflammatory disorders or dysfunction of the muscles of the body, and/or related components of the motor unit (muscles, tendons, fascia, ligaments/capsules, discs, and synovial structures), and related manifestations or conditions.

Nausea means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Contracted Acupuncturist in accordance with professionally recognized, valid, evidence-based standards of practice and includes adult post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy.

Neuromusculoskeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures), and related neurological manifestations or conditions. Neuromusculoskeletal Disorders include Myofascial/Musculoskeletal Disorders and Musculoskeletal Functional Disorders.

Pain means the sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition that may be appropriately

treated by a Contracted Provider in accordance with professionally recognized, valid, evidence-based standards of practice.

Pain Syndrome means an acute or chronic Neuromusculoskeletal Disorder, including Myofascial/Musculoskeletal Disorder or Musculoskeletal Functional Disorder, in which the primary symptom consists of sensations of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition that may be appropriately treated by a Contracted Chiropractor.

Supports and Appliances are support-type devices prescribed by a Contracted Chiropractor which are restricted to the following items to the exclusion of all others: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces. In order for Supports and Appliances to be covered, the Member must be receiving Chiropractic Services from a Contracted Chiropractor for a Neuromusculoskeletal Disorder or Pain Syndrome and have the Supports and Appliances prescribed for that condition.

Urgent Services consist of Covered Services that are Acupuncture Services or Chiropractic Services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Service Area.

CHIROPRACTIC COVERED SERVICES

1. A new patient examination or an established patient exam for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Chiropractic Services. A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.
2. Established patient exams to assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient exam is only covered when used to determine the appropriateness of Chiropractic Services. The established patient exam must be Medically Necessary.
3. Follow-up office visits include manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other service, in various combinations.
4. Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

5. X-rays and laboratory tests are payable in full when provided by or referred by a Contracted Chiropractor and approved by ASH Plans. Radiological consultations are a covered benefit when approved by ASH Plans as Medically Necessary Services and when provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital which has contracted with ASH Plans to provide those services.
6. Chiropractic Supports and Appliances are payable up to a maximum of \$50.00 per year when approved by ASH Plans as Medically Necessary for the treatment of either Neuromusculoskeletal Disorders and/or Pain Syndromes.
7. All Chiropractic Services except for the initial evaluation must be approved by ASH Plans as Medically Necessary for treatment of either Neuromusculoskeletal Disorders and/or Pain Syndromes.
8. Urgent Services.
9. Emergency Services.

CHIROPRACTIC EXCLUSION AND LIMITATIONS

The Chiropractic Benefit does NOT cover:

1. Any services or treatments that are furnished before the date the Member becomes eligible or after the date the member ceases to be eligible under the Member's plan.
2. If the Member's plan requires the Member to obtain a primary care physician referral for Chiropractic Services, any Chiropractic Services or treatments furnished without the required primary care physician referral.
3. Services or treatments that are not approved by ASH Plans as Medically Necessary in accordance with ASH Plans' Clinical Services Management Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; and (c) Emergency Services.
4. Services or treatments delivered by a non-Contracted Provider, except for (a) Emergency Services; (b) Urgent Services; (c) services that are provided upon referral by ASH Plans in situations where such services are not available and accessible to a Member from a Contracted Provider within the Service Area; or (d) services that are provided pursuant to a continuity of care plan approved by ASH Plans.
5. Services, exams (other than an initial examination to determine the appropriateness of Chiropractic Services), and/or treatments for conditions other than Neuromusculoskeletal Disorders and/or Pain Syndromes.
6. Hypnotherapy, behavior training, sleep therapy, and weight programs.
7. Thermography; magnets used for diagnostic or therapeutic use; nerve conduction studies (e.g., EEG, EMG, SEMG, SSEP, and NCV); or electrocardiogram (EKG) studies.

8. Services, clinical laboratory studies, X-rays, Supports and Appliances, and other treatments or products that are classified as Experimental or Investigational. If ASH Plans denies coverage for a therapy for a Member who has a life-threatening or seriously debilitating condition based on a determination by ASH Plans that the therapy is Experimental or Investigational, the Member may be able to request an independent medical review of ASH Plans' determination. The Member should contact ASH Plans' Member Services Department at 1-800-678-9133 for more information.
9. Transportation costs, including local ambulance charges.
10. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology and any diagnostic radiology other than covered plain film studies.
11. Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training or related diagnostic testing.
12. Services or treatments for pre-employment physicals or vocational rehabilitation.
13. Any services or treatments for conditions caused by or arising out of the course of employment or covered under workers' compensation or similar laws.
14. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances; and all support appliances or durable medical equipment, except as defined elsewhere in this Schedule of Benefits.
15. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.
16. Services provided by a chiropractor practicing outside the Service Area, except for Emergency Services or Urgent Services.
17. Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services or other related services.
18. Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
19. Adjunctive physiotherapy modalities and procedures unless provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
20. Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
21. Massage Therapy.
22. Clinical laboratory studies performed in a chiropractor's office, venipuncture.
23. Services rendered in excess of visits or benefit maximums.

24. Any service or supply that is not permitted by state law with respect to the provider's scope of practice.
25. Any services provided by a person who is a Family Member. Family Member means a person who is related to the covered person in any of the following ways: spouse, Domestic Partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member also includes individuals who normally live in the covered person's household.
26. Any services rendered for elective or maintenance care (e.g., services provided to a Member whose treatment records indicate he or she has reached Maximum Therapeutic Benefit).
27. Natural childbirth services.

ACUPUNCTURE COVERED SERVICES

1. A new patient exam or an established patient exam for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Acupuncture Services. A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.
2. Established patient exams to assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient exam is only covered when used to determine the appropriateness of Acupuncture Services. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a copay is required. The established patient exam must be Medically Necessary.
3. Follow-up office visits include the provision of Acupuncture Services and/or a re-evaluation.
4. Adjunctive therapies or modalities such as acupressure, cupping, moxibustion and/or breathing techniques are covered only when provided during the same Course of Treatment and in support of Acupuncture Services. However the following exception applies for the application of acupressure: if (a) a Contracted Acupuncturist would recommend Acupuncture for a Member as a Covered Service but cannot do so in accordance with professionally recognized, valid, evidence-based standards of practice because the insertion of needles is contraindicated (e.g. for a patient with an infectious disease that may be transmitted through blood or other bodily fluids) and (b) professionally recognized, valid, evidence-based standards of practice indicate that acupressure would be efficacious in the treatment of the Member, then Acupuncture Services shall be deemed to include acupressure in that circumstance even if Acupuncture Services are not provided to the Member at the same time and the Member shall be entitled to receive other Adjunctive Therapies or Modalities in conjunction with the provision of acupressure in that circumstance to the same extent as would be the case if the Member were receiving Acupuncture Services.
5. All Acupuncture Services except for the initial evaluation must be approved by ASH Plans as Medically Necessary for the treatment of Neuromusculoskeletal Disorders, Nausea, and/or Pain.
6. Urgent Services.
7. Emergency Services.

ACUPUNCTURE EXCLUSIONS AND LIMITATIONS

The Acupuncture Benefit does NOT cover:

1. Any services or treatments that are furnished before the date the Member becomes eligible or after the date the member ceases to be eligible under the Member's plan.
2. If the Member's plan requires the Member to obtain a primary care physician referral for acupuncture services, any acupuncture services or treatments furnished without the required primary care physician referral.
3. Services or treatments that are not approved by ASH Plans as Medically Necessary, in accordance with ASH Plans' Clinical Services Management Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Acupuncture Services; and (c) Emergency Acupuncture Services.
4. Services or treatments delivered by a non-Contracted Provider, except for (a) Emergency Services; (b) Urgent Services; (c) services provided upon referral by ASH Plans in situations where such services are not available and accessible to a Member from a Contracted Provider within the Service Area; or (d) services that are provided pursuant to a continuity of care plan approved by ASH Plans.
5. Services, exams (other than an initial examination to determine the appropriateness of Acupuncture Services) and/or treatments for conditions other than Neuromusculoskeletal Disorders, Nausea, Pain or pain syndromes.
6. Services, examinations and/or treatments for asthma or addiction, such as nicotine addiction.
7. Hypnotherapy, behavior training, sleep therapy, and weight programs.
8. Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
9. Services and other treatments that are classified as Experimental or Investigational. If ASH Plans denies coverage for a therapy for a Member who has a life-threatening or seriously debilitating condition based on a determination by ASH Plans that the therapy is Experimental or Investigational, the Member may be able to request an independent medical review of ASH Plans' determination. The Member should contact ASH Plans' Member Services Department at 1-800-678-9133 for more information.
10. Radiological x-rays (plain film studies), magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology, and laboratory services.
11. Transportation costs, including local ambulance charges.

12. Education programs, non-medical lifestyle or self-help, or self-help physical exercise training or any related diagnostic testing.
13. Services or treatments for pre-employment physicals or vocational rehabilitation.
14. Services or treatments for conditions caused by or arising out of the course of employment or covered under workers' compensation or similar laws.
15. Air conditioners/purifiers, therapeutic mattresses, supplies or any other similar devices or appliances or durable medical equipment.
16. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.
17. Services provided by an acupuncturist practicing outside the Service Area, except for Emergency Services or Urgent Services.
18. Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services or other related services.
19. Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
20. Adjunctive therapy not associated with acupuncture.
21. Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
22. Acupuncture performed with reusable needles.
23. Any service or supply that is not permitted by state law with respect to the provider's scope of practice.
24. Services rendered in excess of visit or benefit maximums.
25. Massage Therapy.
26. Any services provided by a person who is a Family Member. Family Member means a person who is related to the covered person in any of the following ways: spouse, Domestic Partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member also includes individuals who normally live in the covered person's household.
27. Any services rendered for elective or maintenance care (e.g., services provided to a Member whose treatment records indicate he or she has reached maximum therapeutic benefit).