

Chiropractic Schedule of Benefits

Benefit Plan

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 through 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.

Benefits include Chiropractic Services that are Medically Necessary Services provided by a Contracted Chiropractor for treatment of either Neuromusculoskeletal Disorders and/or Pain Syndromes.

Calculation of Annual Maximum Benefit Limits

Each visit to a Contracted Chiropractor, as described below, requires a Copayment by the Member. A maximum number of visits per calendar year will apply to each Member.

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.

Provider Eligibility

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

Types of Covered Services

a) 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.

b) 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.

c) Follow-up office visits include manipulation of the spine, joints, and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations.

d) Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation and other therapies are only covered when provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

e) X-rays and laboratory tests are payable in full when referred by a Contracted Chiropractor and

approved by ASH Plans as Medically Necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital which has contracted with ASH Plans to provide those services.

f) Chiropractic Supports and Appliances are payable up to a maximum of \$50 per year when approved by ASH Plans for the treatment of either Neuromusculoskeletal Disorders and/or Pain Syndromes.

g) All Chiropractic Services except for the initial evaluation must be approved by ASH Plans as Medically Necessary for the treatment of either Neuromusculoskeletal Disorders and/or Pain Syndromes.

h) Urgent Services.

i) Emergency Services.

Exclusions and Limitations

Benefits do not include services that are not described under “Benefit Plan” and “Types of Covered Services,” above. In addition to any other applicable “limitations” contained elsewhere in the evidence of coverage provided to a Member, ASH Plans shall not be required to furnish benefits in connection with the following:

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 Chiropractor, 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 Chiropractor within the Service Area; or (d) services that are provided pursuant to a continuity of care plan approved by ASH Plans.

5. Services, examinations (other than an initial examination to determine the appropriateness of Chiropractic Services), and/or treatments for conditions other than those related to 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. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology, and any diagnostic radiology other than covered plain film studies.

10. Transportation costs including local ambulance charges.
11. Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training or any related diagnostic testing.
12. Services or treatments for pre-employment physicals or vocational rehabilitation.
13. Any services or treatments 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; all chiropractic 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 Urgent Services or Emergency 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.



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