Health Net

Health Net Health Plan of Oregon, Inc.
BeneFacts: Individual and Family
Topaz First Dollar PPO Plan
Copayment and Coinsurance Schedule ITP2V3/06

The Advantage is yours. This Preferred Provider Organization (PPO) plan gives you flexibility and choice in deciding who will provide your health care. You may receive services from Providers in our PPO network or Providers out of our network. When you receive services from Providers in our PPO network, you gain the advantage of significant cost savings. Under this unique plan, you receive First Dollar benefits, which means we will pay the first $250 of covered charges, per covered person per Calendar Year. Once you've received $250 in covered services per Calendar Year, you then become responsible for deductibles, Copayments and Coinsurance up to your annual out-of-pocket maximum.[7]

PPO Benefits: When you receive covered services from Providers in our PPO network, your expenses include a Calendar Year deductible (if any), fixed dollar amounts for certain services or a fixed percentage that is applied to our contracted rates with PPO Providers. *The percentage of our contracted rate that is your responsibility is shown on this schedule as* **% contract rate**.

When you receive covered services from a Provider in our PPO network, you are not responsible for charges that are above our contracted rates. We recommend that you contact your attending Provider to discuss the ancillary providers that may be used for your services, as Out-of-Network Provider charges will be reimbursed at the Out-of-Network level. **Certain services including but not limited to cardiac services, Home Health Care, home infusion services, organ and tissue transplant services, and Durable Medical Equipment are only covered if provided by a designated Specialty Care Provider. See Article 1.5 of the Basic Benefit Schedule.**

Out-of-Network Benefits: When services are performed by a Provider who is not in our PPO network, your expenses include a Calendar Year deductible, fixed dollar amounts for certain services and a fixed percentage of Usual, Customary and Reasonable (UCR) rates for other services. We pay Out-of-Network Providers based on UCR rates, not on billed amounts. UCR rates may often be less than the amount a Provider bills for a service. Amounts that exceed our UCR rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our UCR payment is shown on this schedule as* **UCR *plus***.

Your benefits are subject to deductibles, Copayments and Coinsurance amounts listed in this schedule.

First Dollar Benefits	**$250 per person per year both In & Out-of-Network[1, 2]**	
	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$250 PPO Network and Out-of-Network combined [3, 4, 7]	
Annual deductible per family	$750 PPO Network and Out-of-Network combined [3, 4, 7]	
Physician/Professional/Outpatient Care		
Women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	25% contract rate [5]	50% UCR *plus* [5, 7]
Routine mammography	25% contract rate [5]	50% UCR *plus* [5, 7]
Physician services, office call	25% contract rate	50% UCR *plus* [7]
Physician services, urgent care center	25% contract rate	50% UCR *plus* [7]
Well Baby care	25% contract rate [5]	50% UCR *plus* [5]
Physician Hospital visits	25% contract rate	50% UCR *plus* [7]
Diagnostic X-ray/EKG/Ultrasound	25% contract rate	50% UCR *plus* [7]
Diagnostic laboratory tests	25% contract rate	50% UCR *plus* [7]
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	25% contract rate	50% UCR *plus* [7]
Allergy and therapeutic injections	25% contract rate	50% UCR *plus* [7]
Maternity delivery care (professional services only)	25% contract rate	50% UCR *plus* [7]
Outpatient rehabilitation therapy -$2,500/year max	25% contract rate	50% UCR *plus* [7]
Outpatient or ambulatory care center	25% contract rate	50% UCR *plus* [7]
Hospital Care		
Inpatient services	25% contract rate	50% UCR *plus* [7]
Inpatient rehabilitation therapy -30 days/year max	25% contract rate	50% UCR *plus* [7]
Emergency Services		
Outpatient emergency room services	25% contract rate	50% UCR *plus* [7]
Inpatient admission from emergency room	25% contract rate	50% UCR *plus* [7]
Emergency ambulance transport -$3,000/year max	25% (UCR *plus* applies to Out-of-Network Providers) [7]	

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For covered services, you are responsible for:

Behavioral health services	PPO Network	Out-of-Network
Mental health - $1,000/year max [6]	25% contract rate [4, 5, 7]	50% UCR plus [4, 5, 7]
Other Services		
Durable Medical Equipment and external Prosthetic Device $5,000/year max	25% contract rate	50% UCR *plus* [7]
Medical supplies (including allergy serums and injected substances)	25% contract rate	50% UCR *plus* [7]
Diabetes management - one initial program per lifetime	25% contract rate	50% UCR *plus* [7]
Blood, blood plasma, blood derivatives	25% contract rate	50% UCR *plus* [7]
TMJ services - $500/lifetime max	50% contract rate [4]	50% UCR *plus* [4, 7]
Home infusion therapy	25% contract rate	50% UCR *plus* [7]
Skilled Nursing Facility care - 60 days/year max	25% contract rate	50% UCR *plus* [7]
Hospice services	25% contract rate	50% UCR *plus* [7]
Home health visits - $1,000/year max	25% contract rate	50% UCR *plus* [7]
Outpatient neurodevelopmental therapy, under age 7 - $1,000/year max	25% contract rate	50% UCR *plus* [7]
Health education - $150/year max for all qualifying classes	Any charges over maximum reimbursement of $50/qualifying class. [4, 5, 7]	
Benefit Maximums		
Annual out-of-pocket maximum per person [2]	$6,000	$12,000
Annual out-of-pocket maximum per family [2]	$18,000	$36,000
Lifetime maximum for authorized organ transplant services	$250,000	Not covered Out-of-Network
Lifetime maximum	$2,000,000 PPO Network and Out-of-Network combined	

Exclusion periods (Refer to Medical and Hospital Service Agreement, Section 8.12)

Allergies & their symptoms, including asthma: 12 months	Mental disorders: 12 months
Elective procedures: 12 months	Organ transplants: 24 months
Pre-existing conditions: 6 months	

Notes

[1] First dollar benefits apply before Member's deductible must be satisfied. Health Net pays 100% of covered services up to $250 for each Member. The maximum payable and maximum allowable amounts are waived until the first dollar benefit is exhausted. After the first dollar benefits are exhausted, office visits are paid at the specified Coinsurance not subject to deductible. Members must satisfy the plan deductible before any other plan benefits apply.

[2] The annual out-of-pocket maximum (OOPM) is the maximum dollar amount of Copayment or Coinsurance that you are required to pay each Calendar Year for most covered services and supplies. Each January 1, the accumulation period renews and a new OOPM requirement begins. The OOPM does not include the annual deductible or annual First Dollar benefits. After you reach the out-of-pocket maximum in a Calendar Year, we will pay your covered services during the rest of that Calendar Year at 100% of our contract rates for PPO services and at 100% of UCR for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed UCR.

[3] After Health Net covers your annual First Dollar benefits, you must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.

[4] Your payments do not apply to the annual out-of-pocket maximum.

[5] Deductible is waived.

[6] To Prior Authorize mental health services, call 800-977-8216.

[7] First Dollar benefits do not apply to mental health, health education or the amount between UCR and billed charges for Out-of-Network Providers. First Dollar benefits also do not apply to benefits added by supplemental riders (other than Preventive care) including but not limited to Well Net, Alcohol Treatment, Dental, Vision and Pharmacy.

This schedule presents general information only. Certain services require Prior Authorization or must be performed by a Specialty Care Provider. Refer to your contract and other benefit materials for details, limitations and exclusions.

Health Net Health Plan of Oregon, Inc. • 888-802-7001 • service@healthnet.com • www.healthnet.com

Health Net Health Plan of Oregon, Inc.
Individual and Family Plan
Prescription Benefits

Supplemental Benefit Schedule PJ4K/06 (MAC A)

Article 1 - Purpose and Function of this Schedule

The purpose of this Schedule is to provide prescription benefits. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Medical and Hospital Service Agreement and its attachments, except as expressly amended by the Benefits article of this schedule, you are entitled to receive benefits set forth in this schedule upon payment of the relevant premium and the Copayments.

Article 2 - Benefits

Coverage includes all Medically Necessary legend drugs, compounded medications of which at least one ingredient is a prescription legend drug, any other drug which under law may only be dispensed by written prescription of a duly licensed health care provider, diabetic supplies, and insulin. Coverage is subject to the qualifications, limitations and exclusions below:

2.1 The amount of drug to be dispensed per filled prescription shall be for such quantities as directed by the Physician, but in no event shall the quantity exceed a 30-day supply when filled in a pharmacy or a 90-day supply when filled through mail order. Benefits are based on FDA approved dosing guidelines. **Some drugs, including but not limited to compounded medications, require Prior Authorization and/or may have a dosage or quantity restriction set by the Plan.**

2.2 All drugs, including insulin and diabetic supplies, must dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area.

2.3 When a generic form of a brand name drug exists, the generic drug will be dispensed and the Tier 1 Copayment shall apply. An approved generic equivalent shall mean a generic drug that has been given an "A" therapeutic equivalent code by the Department of Health and Human Services. If a generic equivalent exists but a brand name drug is requested, you must pay an ancillary charge equal to the difference between the cost of the generic drug and the brand name drug in addition to the Tier 2 Copayment.

2.4 A covered prescription drug or refill will be provided upon payment of the following Copayment. Prescription deductibles, Copayments and other amounts you pay for prescription drugs do not apply toward your plan's other deductibles, out-of-pocket maximums, Copayment maximums, or maximum amounts subject to Coinsurance.

Calendar Year Deductible for Prescription Benefits: $100 per Member.
Maximum Prescription Benefit: $4,000 per Member per Calendar Year.

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	50%	50%
Tier 2	50%	50%
Tier 3	You pay the full cost of the prescription at Health Net's discounted rate.	You pay the full cost of the prescription at Health Net's discounted rate.

Specialty Pharmacy: Certain drugs identified on the PDL with the designation "SP" are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs must be obtained from a designated Specialty Pharmacy Provider. Specialty Pharmacy drugs include, but are not limited to, injectable medications other than insulin that the majority of patients or a caregiver can administer at home after receiving adequate training from a medical professional.

This pharmacy plan does not provide creditable coverage for Medicare Part D.

	Specialty Pharmacy (Per Fill Up to a 30-day Supply)
Specialty Pharmacy	You pay the full cost of the prescription at Health Net's discounted rate.

The Calendar Year Deductible for Prescription Benefits and the Maximum Prescription Benefit include Specialty Pharmacy services.

2.5 The level of benefit you receive is based on the Preferred Drug List (PDL) status of the drug at the time your prescription is filled. The PDL may be revised up to four times per Calendar Year based on the recommendations of the Pharmacy and Therapeutics Committee. Any such changes including additions and deletions from the PDL will be communicated to Participating Providers. Compounded medications are subject to the Tier 3 Copayment.

2.6 Reimbursement (minus the Copayment) will be made for prescriptions filled by a pharmacy other than a Participating Provider pharmacy for Emergency Medical Care rendered outside the Service Area, upon presentation to us of receipts and sufficient documentation to establish the need for Emergency Medical Care.

2.7 Reimbursement (minus the Copayment) will be made for coverable prescriptions filled by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic. For the purposes of 2.7, "urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

Article 3 - Exclusions

The following items are excluded from coverage:

3.1 Drugs and medicines prescribed or dispensed other than as described in this Schedule.

3.2 Early refills other than for changes in directions.

3.3 Over-the-counter drugs other than insulin.

3.4 Therapeutic or prosthetic devices, orthotics and all supplies, even though they might require a prescription, including but not limited to: hypodermic needles and syringes other than for insulin, appliances, support garments, braces, splints, bandages, dressings and other non-medicinal substances regardless of intended use.

3.5 Injectable medications other than those listed as injections on the PDL.

3.6 Dental only drugs.

3.7 Dietary supplements, food, health and beauty aids, and vitamin preparations other than legend prenatal vitamins and legend vitamins with fluoride.

3.8 Drugs for treatment of onychomycosis (nail fungus), nocturnal for enuresis (bed wetting), sexual dysfunction, or infertility; drugs used for weight loss, smoking cessation, sexual enhancement, or sexual performance improvement; growth hormone therapy; and oral nystatin powder.

3.9 Any prescription drug for which an over-the-counter therapeutic equivalent is available.

3.10 Prescription refills due to loss or theft.

3.11 Non-hormonal contraceptive devices, IUDs, contraceptive implants, and contraceptive injectables other than Depo Provera 150mg injection.

3.12 Diabetic supplies other than blood glucose test strips, lancets, insulin syringes and needles.

This pharmacy plan does not provide creditable coverage for Medicare Part D.

Health Net Health Plan of Oregon, Inc.
Preventive Care Benefits
Supplemental Benefit Schedule

In this Supplemental Benefit Schedule, the terms "we," "our" and "us" refer to Health Net Health Plan of Oregon, Inc. and the terms "you" and "your" refer to the Subscriber and to each Enrolled Dependent unless otherwise specified.

Article 1 - Purpose and Function of this Schedule

The purpose of this Supplemental Benefit Schedule is to provide coverage for preventive care benefits. This schedule is an amending attachment to the Basic Benefit Schedule. Subject to all terms, conditions, exclusions and definitions in the Medical and Hospital Service Agreement and its attachments, except as expressly amended by the Benefits article of this schedule, you are entitled to receive benefits set forth in this schedule upon payment of the relevant premium and the Copayment or Coinsurance stated in your benefit schedule. The deductible, if any, is waived for preventive care benefits.

Article 2 - Benefits

2.1 Routine physical examinations. Scheduled routine physical examinations, including complete blood count (CBC), history and physical, urine analysis (UA), chemical profile, and stool hemocult, are covered according to the following schedule:

a. Pediatric (under age 19)

Infant (under age 2)	Eight well-baby exams in the first 24 months.
Early childhood (3 through 5 years)	One exam every year
Late childhood (6 through 11 years)	One exam every 2 years
Adolescent (12 through 18 years)	One exam every year

b. Adult

19 through 40 years	One exam every 3 years
41 through 60 years	One exam every 2 years
Over 60 years	One exam every year

Physical Examinations do not include stress test, EKG, chest x-ray, or sigmoidoscopy unless Medically Necessary.

2.2 Immunizations and inoculations. Immunizations and inoculations routinely administered are covered. Immunizations for the purpose of travel are not covered.

2.3 Family planning. Counseling and assessment for birth control are covered. Diaphragms and non-hormonal contraceptive devices, contraceptive injectables, and Norplant are covered when provided in the doctor's office.

2.4 Vision Screening Exams. Vision screening to determine the need for vision correction is covered. Eye examinations for refractions are not covered. All types of vision hardware and corrective appliances are excluded except as provided under Durable Medical Equipment and Medical Supplies of the Basic Benefit Schedule.

2.5 Circumcisions. Circumcisions for newborn male children are covered.

2.6 Benefits for preventive care services covered under this Supplemental Benefit Schedule are payable at benefit levels indicated on your benefit schedule.

Health Net Health Plan of Oregon, Inc.

Individual and Family Plan Well Net

Supplemental Benefit Schedule CAM36 20-500/06

Article 1 - Purpose and Function of this Schedule

The purpose of this Schedule is to provide coverage for complementary services by Providers of chiropractic, acupuncture, massage therapy, and naturopathic medicine. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Medical and Hospital Service Agreement and its attachments, except as expressly amended by the Benefits provision of this Schedule, you are entitled to receive benefits set forth in this Schedule upon payment of the relevant premiums and Copayments specified in this Schedule.

Article 2 – Copayments

2.1 The copayment for chiropractic, acupuncture and naturopathic services is $20 per visit.

2.2 The copayment for massage therapy services is $25 per visit, with a maximum of 9 visits. Patients have direct access to ASH Networks contracted massage therapists for up to four visits. All visits beyond the first four visits annually must be Prior Authorized by ASH Networks as medically/clinically necessary for myofascial, neuromusculoskeletal or pain syndromes.

2.3 The maximum combined benefit per Calendar Year is $500.

Article 3 - Chiropractic Services

3.1 Chiropractic services are covered as follows:

a. Patients have direct access to ASH Networks contracted chiropractors for their initial visit. A new patient examination is performed by the ASH Networks contracted provider to determine the nature of the member's problem and, if covered services appear warranted, a proposed treatment plan of services to be furnished is prepared. A new patient examination is provided for each new patient. A copay is required.

b. An established patient examination may be performed by the ASH Networks contracted provider to assess the need to continue, extend or change a treatment plan approved by ASH Networks. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a copay is required.

c. Subsequent office visits, as set forth in a treatment plan approved by ASH Networks, may involve an adjustment, a brief reexamination and other services, in various combinations. A copay is required for each visit to the office.

d. Adjunctive therapy, as set forth in a treatment plan approved by ASH Networks, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.

e. X-rays and clinical laboratory tests are payable in full when referred by an ASH Networks contracted chiropractor and approved by ASH Networks. Radiological consultations are a covered benefit when approved by ASH Networks as medically/clinically necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Networks to provide those services.

f. Chiropractic appliances are covered up to a maximum of $50 per year when prescribed by an ASH Networks contracted chiropractor and approved by ASH Networks.

g. All chiropractic services, except for the initial visit, must be Prior Authorized by ASH Networks as medically/clinically necessary for treatment of neuromusculoskeletal conditions.

3.2 Chiropractic Exclusions and Limitations.

a. Services or treatments not approved ASH Networks as medically/clinically necessary, except for a new patient examination and urgent services.

b. Services or treatments not delivered by ASH Networks contracted chiropractors for the delivery of chiropractic care to members, except for urgent services.

c. Services for examinations and/or treatments from ASH Networks contracted chiropractors for conditions other than those related to neuromusculoskeletal disorders.

d. Hypnotherapy, behavior training, sleep therapy and weight programs.

e. Thermography.

f. Services, lab tests, x-rays and other treatments not documented as medically/clinically necessary and appropriate or classified as experimental or investigational and/or as being in the research stage.

g. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any diagnostic radiology other than covered plain film studies.

h. Transportation costs including local ambulance charges.

i. Education programs, non-medical lifestyle or self-help or any self-help physical exercise training or related diagnostic testing.

j. Services or treatments for pre-employment physicals or vocational rehabilitation.

k. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

l. Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment, except as specifically outlined.

m. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

n. Services provided by a chiropractor practicing outside the states of Oregon and Washington (state of residency), except for urgent services.

o. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

p. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

q. Adjunctive therapy not associated with spinal, muscle or joint manipulation.

r. Vitamins, minerals or other similar products.

Article 4 – Acupuncture Services

4.1 Acupuncture services are covered as follows:

a. Patients have direct access to ASH Networks contracted acupuncturists for their initial visit. A new patient examination is performed by the ASH Networks contracted provider to determine the nature of the member's problem and, if covered services appear warranted, a treatment plan of services to be furnished is prepared. A new patient examination is provided for each new patient. A copay is required.

b. An established patient examination may be performed by the ASH Networks contracted provider to assess the need to continue, extend or change a treatment plan approved by ASH Networks. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a copay is required.

c. Subsequent office visits, as set forth in a treatment plan approved by ASH Networks, may involve acupuncture treatment, a brief reexamination and other services in various combinations. A copay is required for each visit to the office.

d. Adjunctive therapy, as set forth in a treatment plan approved by ASH Networks, may involve modalities such as acupressure, moxibustion, cupping and other therapies.

e. All acupuncture services, except for the initial visit, must be Prior Authorized by ASH Networks as medically/clinically necessary for treatment of nausea, pain syndromes or neuromusculoskeletal conditions.

4.2 Acupuncture exclusions and limitations:

a. Services or treatments not approved by ASH Networks as medically/clinically necessary, except for a new patient examination and urgent services.

b. Services or treatments not delivered by ASH Networks contracted acupuncturists for the delivery of acupuncture care to members, except for urgent services.

c. Services for examinations and/or treatments from ASH Networks contracted acupuncturists for conditions other than those related to neuromusculoskeletal disorders, nausea or pain syndromes.

d. Hypnotherapy, behavior training, sleep therapy and weight programs.

e. Thermography.

f. Services, lab tests, x-rays and other treatments not documented as medically/clinically necessary and appropriate or classified as experimental or investigational and/or as being in the research stage.

g. Radiological x-rays, magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology and laboratory services.

h. Transportation costs including local ambulance charges.

i. Education programs, non-medical lifestyle or self-help or self-help physical exercise training or any related diagnostic testing.

j. Services or treatments for pre-employment physicals or vocational rehabilitation.

k. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

l. Air conditioners/purifiers, therapeutic mattresses, supplies, durable medical equipment or appliances, or any other similar device.

m. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

n. Services provided by an acupuncturist practicing outside the states of Oregon and Washington (state of residency), except for urgent services.

o. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

p. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

q. Adjunctive therapy not associated with acupuncture.

r. Vitamins, minerals or other similar products.

s. Nutrition supplements which are Native American, South American, European or of any other origin.

t. Nutrition supplements obtained by member through an acupuncturist, health food store, grocery store or by any other means.

u. Clinical laboratory services or any other type of diagnostic test or service.

Article 5 – Massage Therapy Services

5.1 Massage therapy services are covered as follows:

a. Patients have direct access to ASH Networks contracted massage therapists for up to four visits. All visits beyond the first four visits annually must be Prior Authorized by ASH Networks as medically/clinically necessary for myofascial, neuromusculoskeletal or pain syndromes. A copay is required for each massage therapy session/office visit.

b. After the first four visits, the ASH Networks contracted massage therapist will provide therapeutic massage in support of a covered medical condition. The ASH Networks contracted massage therapist develops an applicable treatment plan and submits it to ASH Networks for approval. A copay is required for each massage therapy session/office visit.

c. Subsequent sessions include therapeutic massage and possibly a brief reassessment of patient status and progress toward therapy goals. A copay is required for each massage therapy session/office visit with the ASH Networks contracted massage therapist. The subsequent session includes all services related to the massage therapy, a brief reassessment if necessary and any consultative support services.

d. Any treatment for a minor under the age of 18 requires parental participation.

5.2 Massage therapy exclusions and limitations:

a. Services or treatments not delivered by ASH Networks contracted providers for the delivery of massage therapy care to members.

b. Services beyond the fourth annual visit for treatments of conditions other than those related to myofascial, neuromusculoskeletal or pain syndromes.

c. Massage therapy services beyond the fourth annual visit that are not Prior Authorized by ASH Networks as medically/clinically necessary.

d. Massage services rendered by a provider of massage therapy services that are not delivered in accordance with the massage benefit plan, including but not limited to limited massage services rendered directly in conjunction with chiropractic, acupuncture or naturopathic services.

e. Hypnotherapy, behavior training, sleep therapy and weight programs.

f. Services and/or treatments not documented as medically/clinically necessary and appropriate or classified as experimental or investigational and/or as being in the research stage.

g. Transportation costs including local ambulance charges.

h. Education programs, non-medical lifestyle or self-help or any self-help physical exercise training or any related diagnostic testing.

i. Services or treatments for pre-employment physicals or vocational rehabilitation.

j. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

k Air conditioners/purifiers, therapeutic mattresses, supplies, durable medical equipment or appliances.

l. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

m. Services provided outside the scope of a massage therapist's license.

n. Hospitalization.

o. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

p. Adjunctive therapy whether or not associated with massage therapy.

q. Vitamins, minerals, nutrition supplements or other similar products.

Article 6 – Naturopathic Medicine Services

6.1 Naturopathic medicine services are covered as follows:

a. Patients have direct access to ASH Networks contracted naturopaths for their initial visit. A new patient examination or consultation, including the history and physical examination, is performed by the ASH Networks contracted provider to determine the nature of the member's problem and, if covered services appear warranted, a treatment plan of services is prepared and furnished to ASH Networks. One new patient examination is provided for each new patient. A copay is required.

b. Subsequent office visits or consultations (including physical examination) are reimbursed as medically/clinically necessary and according to the member's benefit plan. A copay is required.

c. An office visit represents an all-inclusive per diem rate for all services associated with the office visit, including evaluation or reevaluation, any consultative services and any adjunctive services.

d. Adjunctive therapy is limited to that which is allowed by the provider's state scope of practice and, is also limited to non-invasive modalities such as diathermy, electrical stimulation, hot and cold packs, hydrotherapy, manipulation, massage, range of motion exercises and therapeutic ultrasound. Acupuncture is also covered as allowed by the provider's state scope of practice. If provided independent of an examination, a copay is required.

e. Diagnostic tests are limited to those required for further evaluation of the member's condition. Medically/clinically necessary x-rays and laboratory studies must be performed either by an appropriately certified naturopathic doctor or staff member or referred to a facility that has been credentialed to meet ASH Networks criteria.

f. Covered conditions and services are limited to those the provider is qualified to treat or perform pursuant to state licensure and scope of practice, excluding obstetrics, surgery, invasive procedures, psychological

services and services listed as Limitations and Exclusions.

g. All naturopathy services, except for the initial visit, must be Prior Authorized by ASH Networks as medically/clinically necessary for treatment of a covered condition.

6.2 Naturopathic medicine exclusions and limitations:

a. Services or treatments not approved by ASH Networks as medically/clinically necessary, except for a new patient examination, services allowed under an applicable treatment plan threshold and urgent services.

b. Services or treatments not delivered by ASH Networks contracted providers for the delivery of naturopathic care to members, except for urgent services.

c. Services for examinations and/or treatments for conditions that are not listed as a covered condition or listed as an exclusion.

d. Immunizations, vaccinations, injectables and intravenous infusions (does not include venipuncture for the purpose of obtaining blood samples for laboratory studies).

e. Preventive health studies such as PAP smears, PSA studies, mammograms, etc. Are not available under the Naturopathy Benefit. Members seeking such services should consult their primary physician.

f. Hypnotherapy, behavior training, sleep therapy and weight programs.

g. Thermography

h. Services, lab tests, x-rays and other treatments not documented as clinically/medically necessary and appropriate; those classified as experimental or investigational; those that are in the research stage; and/or those not specifically referenced as covered diagnostic tests in the naturopathy covered services section above.

i. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and diagnostic radiology other than covered plain film studies.

j. Transportation costs including local ambulance charges.

k. Education programs, lifestyle or self-help programs or any self-help physical exercise training or related diagnostic testing.

l. Services or treatments for pre-employment physicals or vocational rehabilitation.

m. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

n. Air conditioners/purifiers, therapeutic mattresses, supplies, durable medical equipment or appliances.

o. Prescription drugs or medicines.

p. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

q. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

r. Adjunctive therapy that is considered by ASH Networks to be invasive or not listed on the payor summaries.