



**Summary of Benefits – California EPO**

**1. Read Your Certificate of Insurance Carefully.** This outline of coverage provides a very brief description of some important features of your plan. This is not the insurance contract and only the actual group policy provisions will control. The Certificate of Insurance itself sets forth, in detail, the rights and obligations of both you and American Specialty Health Insurance Company. It is, therefore, important that you **read your Certificate of Insurance carefully!**

**2. Limited Supplemental Group Health Coverage.** This category of coverage is designed to provide, to persons insured, specified limited benefits for complementary health care services that supplement those benefits that may be available under major-medical plans. Benefits are available ONLY to treat the conditions specified in the Certificate of Insurance for the types of services specified in the Certificate of Insurance. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

**3. Benefits of This Plan.** The benefits covered under your plan include the following:

<b>COVERED CLINICAL SERVICES<sup>1</sup></b>	<b>NETWORK</b>	<b>NON-NETWORK</b>
<b>Chiropractic and Manual Manipulation Services for Neuromusculoskeletal Disorders and Pain Syndromes</b>	<b>\$10 copayment per insured, per visit</b>	Coverage is allowed only for emergency services.
Initial new patient exam – one every three years (per provider)	See above	See above
Established patient exams	See above	See above
Follow-up office visits	See above	See above
Adjunctive physiotherapy modalities and procedures	See above. If provided to the same insured during the same visit as an exam, follow-up visit, or other adjunctive services, then only one copayment applies to the visit.	See above
X-rays, radiological consultations, and clinical lab studies	No copayment Maximum Benefit: \$300 per insured, per calendar year	See above
Supports and appliances	No copayment Maximum Benefit: \$50 per insured, per calendar year.	See above
<b>Maximum Annual Visit Limits (combined for all provider types listed above)</b>	<b>30</b>	<b>NA; no coverage</b>

**Access to Providers of Covered Clinical Services**

In California, you may access any appropriately licensed provider without a physician referral for each of the Covered Clinical Services listed above. In some states, however, the scope of practice for certain types of providers may require that either a diagnosis, referral, or a specific prescriptive order be obtained from specified providers prior to the provider with the restricted scope of practice providing treatment to persons in that state. For acupuncture services in Indiana, Massachusetts, Nebraska, New Jersey, Ohio, Pennsylvania and Texas scope of practice limitations require some or all of the following: a written referral or diagnosis from, or a recent examination by, specified providers (such as a medical doctor or physician) before you may be treated by certain types of acupuncture providers in those states. For dietetic services in Alabama, California and Tennessee scope of practice limitations require a written referral by a medical physician (M.D. or D.O.) before a person may be treated by dietetic providers. Claims for Covered Services received from such providers that are submitted to ASH Insurance must include evidence of such referrals in order for the claim to be complete. For more information about scope of practice limitations application to different provider types throughout the country, you may contact our customer service department toll free at 877-430-8092.

**Access to Covered Fitness Services**

To access Covered Fitness Services you must submit a completed Physician Recommendation Form.

**Exclusions, Reductions, and Limitations of This Plan.**

Covered services are limited to the diagnosis and treatment of the conditions specified in the chart included above and as specified in the Covered Services section of your Certificate of Insurance. Exclusions, reductions and limitations specific to each type of coverage available under your plan are provided in detail at the end of each benefit rider in the Covered Services section of your Certificate of Insurance. Typical exclusions, reductions and limitations include, but are not limited to the following: services determined as not being medically necessary; services performed by providers who are not credentialed and/or contracted with American Specialty Health Insurance Company and who are not duly licensed practitioners; medical equipment, devices or appliances; transportation costs, prescription drugs; education programs; auxiliary aids or services; hypnotherapy, behavior therapy, sleep therapy and weight programs; maintenance care and experimental or investigational services.

**Renewability of This Plan.** Your insurance will end as of the first of these dates:

1. The last day of the period for which contribution is made, if a required premium contribution is not made when due.
2. The date you cease to be eligible for insurance.
3. The date of termination of the group policy.
4. The date your coverage under the plan sponsor's underlying group health care plan terminates.
5. If you knowingly furnished to us false, incorrect, or incomplete information which is material to the acceptance of your application, we may, upon written notice, void your coverage as if it had never been in effect.

A specific benefit under your Certificate of Insurance terminates on the date that benefit is no longer provided under the Certificate of Insurance.

Under applicable state and federal laws, you may have the right to elect to remain covered under your Certificate of Insurance, provided such election is timely and an appropriate provision is made for the applicable premium payment. See the Continuation Rights section of your Certificate of Insurance

**Premium for This Plan.** A portion of the premium for this plan is paid for by your plan sponsor. Your contribution to the premium may be obtained from your plan sponsor.

---



**Summary of Benefits – California EPO**

**1. Read Your Certificate of Insurance Carefully.** This outline of coverage provides a very brief description of some important features of your plan. This is not the insurance contract and only the actual group policy provisions will control. The Certificate of Insurance itself sets forth, in detail, the rights and obligations of both you and American Specialty Health Insurance Company. It is, therefore, important that you **read your Certificate of Insurance carefully!**

**2. Limited Supplemental Group Health Coverage.** This category of coverage is designed to provide, to persons insured, specified limited benefits for complementary health care services that supplement those benefits that may be available under major-medical plans. Benefits are available ONLY to treat the conditions specified in the Certificate of Insurance for the types of services specified in the Certificate of Insurance. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

**3. Benefits of This Plan.** The benefits covered under your plan include the following:

<b>COVERED CLINICAL SERVICES<sup>1</sup></b>	<b>NETWORK</b>	<b>NON-NETWORK</b>
<b>Chiropractic and Manual Manipulation Services for Neuromusculoskeletal Disorders and Pain Syndromes</b>	<b>\$10 copayment per insured, per visit</b>	Coverage is allowed only for emergency services.
Initial new patient exam – one every three years (per provider)	See above	See above
Established patient exams	See above	See above
Follow-up office visits	See above	See above
Adjunctive physiotherapy modalities and procedures	See above. If provided to the same insured during the same visit as an exam, follow-up visit, or other adjunctive services, then only one copayment applies to the visit.	See above
X-rays, radiological consultations, and clinical lab studies	No copayment Maximum Benefit: \$300 per insured, per calendar year	See above
Supports and appliances	No copayment Maximum Benefit: \$50 per insured, per calendar year.	See above
<b>Maximum Annual Visit Limits (combined for all provider types listed above)</b>	<b>30</b>	<b>NA; no coverage</b>

**Access to Providers of Covered Clinical Services**

In California, you may access any appropriately licensed provider without a physician referral for each of the Covered Clinical Services listed above. In some states, however, the scope of practice for certain types of providers may require that either a diagnosis, referral, or a specific prescriptive order be obtained from specified providers prior to the provider with the restricted scope of practice providing treatment to persons in that state. For acupuncture services in Indiana, Massachusetts, Nebraska, New Jersey, Ohio, Pennsylvania and Texas scope of practice limitations require some or all of the following: a written referral or diagnosis from, or a recent examination by, specified providers (such as a medical doctor or physician) before you may be treated by certain types of acupuncture providers in those states. For dietetic services in Alabama, California and Tennessee scope of practice limitations require a written referral by a medical physician (M.D. or D.O.) before a person may be treated by dietetic providers. Claims for Covered Services received from such providers that are submitted to ASH Insurance must include evidence of such referrals in order for the claim to be complete. For more information about scope of practice limitations application to different provider types throughout the country, you may contact our customer service department toll free at 877-430-8092.

**Access to Covered Fitness Services**

To access Covered Fitness Services you must submit a completed Physician Recommendation Form.

**Exclusions, Reductions, and Limitations of This Plan.**

Covered services are limited to the diagnosis and treatment of the conditions specified in the chart included above and as specified in the Covered Services section of your Certificate of Insurance. Exclusions, reductions and limitations specific to each type of coverage available under your plan are provided in detail at the end of each benefit rider in the Covered Services section of your Certificate of Insurance. Typical exclusions, reductions and limitations include, but are not limited to the following: services determined as not being medically necessary; services performed by providers who are not credentialed and/or contracted with American Specialty Health Insurance Company and who are not duly licensed practitioners; medical equipment, devices or appliances; transportation costs, prescription drugs; education programs; auxiliary aids or services; hypnotherapy, behavior therapy, sleep therapy and weight programs; maintenance care and experimental or investigational services.

**Renewability of This Plan.** Your insurance will end as of the first of these dates:

1. The last day of the period for which contribution is made, if a required premium contribution is not made when due.
2. The date you cease to be eligible for insurance.
3. The date of termination of the group policy.
4. The date your coverage under the plan sponsor's underlying group health care plan terminates.
5. If you knowingly furnished to us false, incorrect, or incomplete information which is material to the acceptance of your application, we may, upon written notice, void your coverage as if it had never been in effect.

A specific benefit under your Certificate of Insurance terminates on the date that benefit is no longer provided under the Certificate of Insurance.

Under applicable state and federal laws, you may have the right to elect to remain covered under your Certificate of Insurance, provided such election is timely and an appropriate provision is made for the applicable premium payment. See the Continuation Rights section of your Certificate of Insurance

**Premium for This Plan.** A portion of the premium for this plan is paid for by your plan sponsor. Your contribution to the premium may be obtained from your plan sponsor.

---