Health Net Health Plan of Oregon, Inc.

PPO Family High Deductible Health Plan

Copayment and Coinsurance Schedule HD30008060/12

PPO: Two plans, many choices. In health insurance, PPO stands for Preferred Provider Organization. For you, PPO means that you have flexibility and choice in deciding who will provide your health care. That's because this plan lets you receive services from Providers in our PPO network or Providers out of our network. Who performs the services determines which benefit level applies to covered services and how much you will pay out-of-pocket. To confirm whether a Provider participates in our PPO network and to verify which benefit level will apply to a covered service, please contact one of our Customer Contact Center representatives.

PPO Benefits: When you receive covered services from Providers in our PPO network, your expenses include a Calendar Year deductible, 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 treating Provider to discuss the other types of 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 Birthing Center services, Home Health Care, infusion services that can be safely administered in the home or in a home infusion suite, organ and tissue transplant services, Durable Medical Equipment, and Prosthetic Devices/Orthotic Devices are covered only if provided by a designated Specialty Care Provider.**

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 Maximum Allowable Amount (MAA) rates for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible: Family coverage	$3,000 [1]	$6,000 [1]
Physician/Professional/Outpatient Care		
Preventive care, women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	No charge [2]	40% MAA [2]
Routine mammography	No charge [2]	40% MAA [2]
Physician services, office call	20% contract rate	40% MAA
Physician services, urgent care center	20% contract rate	20% MAA
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/EKG/Ultrasound	20% contract rate	40% MAA
Diagnostic laboratory tests	20% contract rate	40% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	20% contract rate	40% MAA
Allergy and therapeutic injections	20% contract rate	40% MAA
Maternity delivery care (professional services only)	20% contract rate	40% MAA
Outpatient rehabilitation therapy – 30 days/year max	20% contract rate	40% MAA
Outpatient at Ambulatory Surgery Center	15% contract rate	40% MAA
Outpatient at Hospital based facility	20% contract rate	40% MAA
Hospital Care		
Inpatient services [3]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA

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	For covered services, you are responsible for:	
	PPO Network	**Out-of-Network**
Emergency Services		
Outpatient emergency room services	20% contract rate	20%
Inpatient admission from emergency room	20% contract rate	20%
Emergency ground ambulance transport – 3 trips/year max	20%	20%
Emergency air ambulance transport - $10,000/year max	20%	20%
Behavioral Health Services – Chemical Dependency and Mental or Nervous Conditions		
Physician services, office call [4]	20% contract rate	40% MAA
Outpatient or ambulatory care center [4]	20% contract rate	40% MAA
Inpatient services [4]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment – $5,000/year max	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management - one initial program	20% contract rate	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate	50% MAA
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-oral anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Health education	Not covered	Not covered
Benefit Maximums		
Annual out-of-pocket maximum: Family coverage [5]	$6,000	$18,000
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

[1] You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims. Family coverage means the Subscriber and spouse; the Subscriber and child(ren); or the Subscriber, spouse and child(ren). Under family coverage, each Member's covered expenses count toward the deductible, but the specified family coverage deductible must be met before Health Net pays any claims.

[2] Deductible is waived.

[3] The above Coinsurance for inpatient Hospital services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to an intermediate or intensive care nursery, a separate Coinsurance for inpatient Hospital Services will apply.

[4] For mental health or Chemical Dependency services call 800-977-8216.

[5] The annual out-of-pocket maximum includes the annual deductible. 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 MAA for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed MAA.

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

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Health Net Health Plan of Oregon, Inc.
Prescription Benefits
SUPPLEMENTAL BENEFIT SCHEDULE
NMSAHD80/12 (NO MAC S)

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.

Purpose and Function of this Schedule

The purpose of this Schedule is to provide prescription benefits to Subscriber Groups selecting this supplemental benefit in addition to the basic benefits. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Health Net Health Plan of Oregon, Inc. Group Medical and Hospital Service Agreement and its attachments, except the exclusion of prescription drugs in the Exclusions and Limitations section of the Basic Benefit Schedule, You are entitled to receive benefits set forth in this Schedule upon payment of the relevant premium, deductible and Coinsurance.

Benefits

Coverage includes all Medically Necessary legend drugs, compounded medications of which at least one ingredient is a prescription legend drug, orally administered anticancer medications, preventive pharmacy medications, women's contraception methods supported by the Health Resources and Services Administration (HRSA) guidelines, and 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:

- 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.**

- All drugs, including insulin and diabetic supplies, must be prescribed by a Participating Provider or by a Physician under Referral and must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area. The requirement that drugs must be prescribed by a Participating Provider or by a Physician under Referral does not apply under a Triple Option, PPO, or Flex Net Plan.

- Coinsurance and/or Copayments shall be as follows for each prescription or refill. Deductible, Coinsurance and/or Copayment amounts you pay for prescription drugs apply toward your medical plan deductible and out-of-pocket maximum.

Calendar Year Deductible for Prescription Benefits: Refer to your medical plan deductible. Specialty Pharmacy services, orally administered anticancer medications, preventive pharmacy medications, or women's contraception methods apply toward your medical plan deductible and Out-of-Pocket maximum.

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	20%	20%
Tier 2	20%	20%
Tier 3	20%	20%
Specialty Pharmacy	20%	Mail order not available
Orally administered anticancer medications	20%	Mail order not available

This pharmacy plan provides creditable coverage for Medicare Part D if you are not currently enrolled in Medicare.
If you are currently enrolled in Medicare, please call our Customer Contact Center to find out if your specific plan provides creditable coverage.

Preventive Pharmacy and Women's contraception methods	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived

- Specialty Pharmacy: Certain drugs identified on the Preferred Drug List (PDL) are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs are high cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and having significantly higher cost than traditional pharmacy benefit drugs.

- The level of benefit you receive is based on the 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 coinsurance. Brand name drugs with generic equivalents are subject to the Tier 3 coinsurance as soon as a generic becomes available.

- Preventive Pharmacy. Preventive Pharmacy medications require a prescription and are limited to prescription drugs and over-the-counter medications that are determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations. A listing of these medications may be identified at the following USPSTF website: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. No deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available, no deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/ or Coinsurance will apply to brand name drugs that have generic equivalents.

  Compounded medications and prescriptions or refills dispensed by a Non-Participating Provider pharmacy are not covered.

- Women's contraception methods. Generic class Food and Drug Administration approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered when dispensed by a Participating Provider pharmacy. No deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available, no deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/ or Coinsurance will apply to brand name drugs that have generic equivalents.

  Abortifacient drugs, compounded medications, over-the-counter methods, devices and supplies, and prescriptions or refills dispensed by a Non-Participating Provider pharmacy are not covered.

- Reimbursement (minus the coinsurance) 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 of receipts to Health Net Oregon and sufficient documentation to establish the need for Emergency Medical Care.

- Reimbursement (minus the coinsurance) 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 these purposes, "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.

Exclusions

The following items are excluded from coverage:

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

- Early refills other than for changes in directions.

- Over-the-counter drugs other than insulin and preventive pharmacy medications as noted above in this Schedule.

- Over-the-counter contraceptive methods, devices and supplies.

This pharmacy plan provides creditable coverage for Medicare Part D if you are not currently enrolled in Medicare.
If you are currently enrolled in Medicare, please call our Customer Contact Center to find out if your specific plan provides creditable coverage.

- Diabetic supplies other than blood glucose test strips, lancets, insulin syringes and needles.
- 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.
- Injectable medications other than those listed on the PDL.
- Dental only drugs.
- Dietary supplements, food, health and beauty aids, and vitamin preparations other than legend prenatal vitamins and legend vitamins with fluoride.
- Drugs for the treatment of onychomycosis (nail fungus), nocturnal enuresis (bed-wetting), sexual dysfunction, or infertility; drugs used for weight loss, sexual enhancement, or sexual performance improvement; growth hormone therapy; oral nystatin powder.
- Any prescription drug for which an over-the-counter therapeutic equivalent is available.
- Prescription refills due to loss or theft.
- Drugs and medicines used for diagnostic purposes.
- Methadone maintenance treatment for the purpose of long term opiate craving reduction.

This pharmacy plan provides creditable coverage for Medicare Part D if you are not currently enrolled in Medicare.
If you are currently enrolled in Medicare, please call our Customer Contact Center to find out if your specific plan provides creditable coverage.

Health Net Health Plan of Oregon, Inc.

Well Net

SUPPLEMENTAL BENEFIT SCHEDULE NXCAM15-1000/12

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 Group 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.

Copayments and Maximums

Calendar Year Deductible for Well Net benefits: Refer to your medical plan deductible. Payments you make will apply toward your medical plan deductible and Out-of-Pocket maximum.

- The Coinsurance for chiropractic, acupuncture and naturopathic services is 20% after deductible.
- The Coinsurance for massage therapy services is 20% after deductible, with a maximum of 18 visits.
- The maximum combined benefit per Calendar Year is $1,000.

Chiropractic Services

- 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 Copayment 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 Copayment 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 Copayment 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.

- 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.

Acupuncture Services

- 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 Copayment 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 Copayment 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 Copayment 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.

- 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.

Massage Therapy Services

- 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 Copayment 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 Copayment 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 Copayment 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.

- 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.

Naturopathic Medicine Services

- 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 Copayment 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 Copayment 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 Copayment 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.

- 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 services, such as those defined by the following: a) United States Preventive Services Task Force (USPSTF) recommended type "A" and "B" services; b) Immunizations and inoculations as recommended by the Advisory Committee on immunization Practices of the Center for Disease Control (CDC); c) Pediatric preventive care and screenings, as supported by the Health Resources and Services Administration (HRSA) guidelines; d) Women's health care services not included in the "Preventive Care" section of the Basic Benefit Schedule, as supported by HRSA guidelines; e) Other USPSTF recommendations for breast cancer screening, mammography and prevention, 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