

When you need to access your American Specialty Health Insurance Company (ASH Insurance) complementary health care benefits from clinical providers, just follow these simple steps:

### Accessing "In-Network" Benefits

1. Simply select a contracted provider of your choice:
  - Visit our Web site at [www.ashcompanies.com](http://www.ashcompanies.com) to search for a contracted provider, or
  - Call Customer Service toll free at **877-430-8092** from 5 a.m. to 6 p.m., Monday-Friday, (PST).
    - No referral required.<sup>1</sup>
    - You may change providers at any time.
2. Call the ASH Insurance provider directly to schedule an appointment.
3. When you arrive for your appointment:
  - Your provider will verify your eligibility status using your ASH Insurance ID Card.<sup>2</sup>
  - You will be asked to complete any health history forms required by the provider.
  - You will simply pay your designated copayment for services rendered.

### Accessing "Out-of-Network" Benefits

1. Select any non-participating provider:
  - ASH Insurance's "Out-of-Network" benefit provides you with coverage should you choose to seek care from a non-participating provider. Please refer to your Certificate of Insurance for details of your "In-Network" and "Out-of-Network" benefits.
    - No referral required.<sup>1</sup>
    - You may change providers at any time.
2. Call the provider directly to schedule an appointment.
3. Your "Out-of-Network" responsibility:
  - ASH Insurance will pay the percentage of billed charges specified in your Certificate of Insurance up to the benefit maximum after your deductible, if any, has been met. You are responsible for any remaining amount of the billed charges. Refer to your Certificate of Insurance or Summary of Benefits for details.
4. Submit your "Out-of-Network" claims:
  - Submit claims for "Out-of-Network" services to: ASH Insurance, P.O. Box 509077 San Diego, CA 92150. It is not necessary to submit claims if your "Out-of-Network" provider has already done so on your behalf.

Review and approval of a health care service does not constitute eligibility for benefits and coverage pursuant to the policy or contract.

<sup>1</sup>For acupuncture services in some states, 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. 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 written referral by a medical physician (M.D. or D.O.) before a person may be treated by dietetic providers in those states. 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 applicable to different provider types throughout the country, you may contact our customer service department toll free at 877-430-8092. Or, refer to your Certificate of Insurance or Summary of Benefits for additional details.

<sup>2</sup>Your ID card also reflects ASH Insurance's toll-free Customer Service number to verify benefits or coverage.

Questions? Call Customer Service toll free at **877-430-8092**, 5 a.m. to 6 p.m., Monday-Friday, (PST).

**American Specialty Health Insurance Company  
Limited Supplemental Group Health Coverage  
PPO OUTLINE OF COVERAGE**

**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:

COVERED SERVICES*	IN-NETWORK	OUT-OF-NETWORK
<b>Chiropractic and Manual Manipulation Services for Neuromusculoskeletal Disorders</b>	<b>\$15 copayment per insured, per visit</b>	<b>Benefit Amount: 50% Maximum Benefit: \$30 per insured, per visit</b>
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**	Benefit Amount: 50% Maximum Benefit: \$100 per insured, per calendar year**
Supports and appliances	No copayment Maximum Benefit: \$50 per insured, per calendar year, combined with related out-of-network benefits.	Benefit Amount: 50% Maximum Benefit: \$20 per insured, per item; \$50 per insured per calendar year, combined with related in-network benefits.

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COVERED SERVICES*	IN-NETWORK	OUT-OF-NETWORK
<b>Acupuncture Services for Neuromusculoskeletal Disorders, Nausea, or Pain</b>	\$15 copayment per insured, per visit	Benefit Amount: 50% Maximum Benefit: \$30 per insured, per visit
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 therapy	See above. If provided to the same insured during the same visit as an exam, follow-up visit, or other adjunctive therapies, then only one copayment applies to the visit.	See above
<b>Massage Therapy Services for Treatment of Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders, or Pain Syndromes</b>	\$15 copayment per insured, per visit	Benefit Amount: 50% Maximum Benefit: \$30 per insured, per visit
Individual therapy assessment -- one every three years (per provider)	See above	See above
Established patient therapy assessments	See above	See above
Massage therapy sessions	See above	See above
<b>Maximum Annual Visit Limits*** (combined for all provider types, as well as in-network and out-of-network providers))</b>	30	10

\*Not all services are available in states outside of California. Claims are subject to review for medical/clinical necessity.

\*\*X-rays, radiological consultations and clinical lab studies performed by an in-network provider but referred by an out-of-network provider are treated as out-of-network services.

\*\*\*Each visit to an in-network provider in a calendar year will reduce the number of visits available under the out-of-network benefits for the rest of that calendar year. Similarly, each visit to an out-of-network provider in a calendar year will reduce the number of visits available under the in-network benefits for the rest of that calendar year.

#### Access to Providers

In California, you may generally access any appropriately licensed provider without a physician referral for each of the services listed on the previous page. In states outside of California, 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 more information about scope of practice limitations applicable to different Network Provider types throughout the country, you may access our Web site at [www.ashcompanies.com](http://www.ashcompanies.com) or contact our customer service department at 1-877-430-8092.

**4. Exceptions, 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/clinically necessary; services performed by providers who are not contracted with American Specialty Health Insurance Company and who are not duly licensed practitioners; nutritional supplements; herbal supplements; medical equipment, devices or appliances; transportation costs, prescription drugs; education programs; auxiliary aids or services; hypnotherapy, behavior therapy, sleep therapy and weight programs; and experimental or investigational services.

# Employee Enrollment Form



AMERICAN SPECIALTY HEALTH INSURANCE COMPANY P.O. BOX 509002 SAN DIEGO, CA 92150-9002 ATTENTION: ENROLLMENT DEPARTMENT PHONE (800) 848-3555 Fax: (619) 557-2343

### REASON FOR SUBMISSION

New application     Change of address/name     Add dependent     Delete dependent (list name below)     Other: \_\_\_\_\_

### EMPLOYEE INFORMATION

Last name	First name	MI	Home phone ( )	Work phone ( )	E-mail
Address		City	State	Zip	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Employer name	Group # <b>13575</b>	Health plan/Insurance carrier	Member ID	Effective date	Social Security number

### ELIGIBLE DEPENDENTS TO BE ENROLLED

<input type="checkbox"/> Spouse <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	MI	Birth date	E-mail
<input type="checkbox"/> Domestic Partner <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	MI	Birth date	E-mail
<input type="checkbox"/> Dependent <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	MI	Birth date	E-mail
Address (if different from above)		City	State	Zip	Phone Number (if different from above)
<input type="checkbox"/> Dependent <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	MI	Birth date	E-mail
Address (if different from above)		City	State	Zip	Phone Number (if different from above)
<input type="checkbox"/> Dependent <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	MI	Birth date	E-mail
Address (if different from above)		City	State	Zip	Phone Number (if different from above)

Are you capable of understanding communications written in English?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your primary language? _____
Is a domestic partner listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, please attach verification of the domestic partnership (e.g., a copy of your Declaration of Domestic Partnership))
If additional Dependents, please attach an additional application form		
Are any of the above dependents a full or part time College or University student?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, please attach a Student Verification Form)
Are any of the above dependents that are over 18 disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, please attach a completed Disability Certification form)
Are any of the above dependents covered due to a court order?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, please attach a copy of the Court Order)
Do you or anyone listed have any other complementary benefits? (See Coverage Types below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, complete section below)

Name(s)	Other employer name & address	Insurance ID/SSN
Insurance company name	Policy number	Effective date
		Coverage type (check applicable coverage type): <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Dietetics
Name(s)	Other employer name & address	Insurance ID/SSN
Insurance company name	Policy number	Effective date
		Coverage type (check applicable coverage type): <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Dietetics

### OTHER INFORMATION

I authorize the deduction from my earnings of the required contribution toward the cost of insurance. I agree to allow any health care provider and any firm or insurer to release my personal information, including medical record information, to American Specialty Health Insurance Company (ASHIC) and its contracted health professionals, vendors, representatives and/or agents to fulfill their obligations under the terms of the plan under which I am enrolling myself and my dependents. I attest that the information provided herein is true and accurate to the best of my knowledge. I understand any false statements may invalidate coverage. I understand that this Authorization is valid for the term of coverage under the plan. I understand that I may revoke this Authorization at any time by contacting ASHIC and making a revocation. I understand that I am entitled to receive a copy of this form. [Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony.]

- I have read, understand and agree to the terms and conditions on this form.
- As a parent or guardian, I authorize the participation of any enrollee under the age of 18.

Signature:	Date:
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