American Specialty Health Group, Inc.
Chiropractic Practitioner Services Agreement (Florida)
Attachment D: Client Summaries
Issued March 2024
Effective January 2024

Please see individual Client Summaries for details regarding the Fee Schedule Amounts, Payment Amounts, and other requirements allowed and required by each individual Client and/or ASH Group.

In the event of an inconsistency between the Practitioner Services Agreement and/or any attachment thereto or the ASH Group Operations Manual, and this Attachment D (Client Summaries), the terms of the Client Summaries and Attachment I (State Specific Requirements) shall control the rights and duties of the Parties. In the event of an inconsistency between Attachment D (Client Summaries) and Attachment I (State Specific Requirements), the provisions of Attachment I shall control the rights and duties of the Parties.

The following ASH Group Clients are currently eligible:

1) American Specialty Health Group, Inc. Seamless Accounts (Benefit Plan)
2) American Specialty Health Group, Inc. Seamless Accounts (Habilitative Care; Benefit Plan)
3) American Specialty Health Group, Inc. Seamless Accounts (Subluxation; Benefit Plan)
4) Anthem Blue Cross and Blue Shield (Blue Direct, Blue Open Access HMO & POS, PPO, and Indemnity; Network Access Plan)
5) Anthem Blue Cross and Blue Shield (HMO, HMO Open Access, POS, POS Open Access & PPO; Benefit Plan)
6) Ascension Complete (Medicare Advantage HMO; Benefit Plan)
7) Centivo (Benefit Plan)
8) ChooseHealthy Program
9) Cigna Healthcare (Benefit Plan)
10) Florida Blue (Benefit Plan)
11) Florida Blue - City of Jacksonville (Benefit Plan)
12) Florida Blue (Medicare Advantage HMO & PPO; Benefit Plan)
13) Healthfirst (Medicare Advantage PPO; Benefit Plan)
14) Providence Health Plan (Signature, Choice, Connect, Extend, PEBB & Intel Connected Care; Network Access Plan)
15) Simply Healthcare Plans, Inc. - Clear Health Alliance (Florida Healthy Kids (SCHIP) & Medicaid MMA; Medicaid Benefit Plan)
16) Simply Healthcare Plans, Inc. (Medicare Advantage HMO & PPO; Benefit Plan)
17) Truli for Health (HMO; Benefit Plan)
18) Ultimate Health Plans (Medicare Advantage HMO; Benefit Plan)

Attached to Attachment D are the Client Summaries listed above, plus applicable fee schedules.

ASH Group reserves the right to change or modify any current or future Client Summaries, and/or add or delete any current or future Client Summaries set forth in this Attachment D at any time by providing written notice to the Contracted Practitioner.

Client Summaries and Fee Schedules
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American Specialty Health Group, Inc. Seamless Accounts
(Benefit Plan)

Revised 12/1/23

TYPE OF PLAN/EMPLOYER: American Specialty Health Group, Inc. (ASH Group) offers and/or administers chiropractic benefits to health plans and employer groups nationwide. Under this plan, Members covered by an eligible health plan or employer group may access a Contracted Practitioner in any state. Members may be covered under a regional health plan in another state and have reciprocity when traveling nationwide, on business or personal, or Members residing outside their health plan service area, may seek services from a Contracted Practitioner. Please see Attachment D-1 to this Client Summary for a complete list of eligible health plans and employer groups.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered conditions include musculoskeletal and related disorders and pain syndromes as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may not limit this election to specific health plan clients. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: If covered, according to the "Services Fee Schedule D" attached. (Contracted Practitioner may bill Chiropractic Manipulative Treatment separately.)

Chiropractic Manipulative Treatment: If covered, according to the "Services Fee Schedule D" attached. The Chiropractic Fee Schedule represents an all-inclusive maximum reimbursable amount for the Chiropractic Manipulative Treatment(s) (CMT), except Adjunctive Therapy associated with the CMT(s). When an extraspinal CMT is billed with a spinal CMT it will be included in the maximum reimbursable amount for CMT. This CMT includes all services related to the CMT(s), including a re-evaluation, and any consultative services.

Adjunctive Therapy: If covered, according to the "Services Fee Schedule D" attached. The Chiropractic Fee Schedule represents an all-inclusive, maximum reimbursable amount for all Adjunctive Therapy services.

Special Services: If covered, according to the "Services Fee Schedule D" attached.

X-Rays: If covered, according to the "X-Ray Fee Schedule A" attached or refer to an ASH Group ancillary radiology provider.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: If covered, Laboratory Services must be referred to an ASH Group ancillary laboratory provider.

Supports and Appliances: If covered, according to the "Supports and Appliances Fee Schedule A1" attached. Verify benefits with ASH Group as specified below.

Sentara: Members have different benefit maximums that should be verified when checking eligibility and coverage for a Member.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an identification card from a health plan/employer group identified on Attachment D-1. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Certain employer groups do not require the routine submission of "MNR Forms." Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Attachment D-1
American Specialty Health Group, Inc. Seamless Accounts
(Benefit Plan)

LIST OF ELIGIBLE HEALTH PLANS/EMPLOYER GROUPS:	EFFECTIVE DATES:
1) Aetna (Medicare Advantage POS & PPO)	January 1, 2023
2) Alignment Healthcare (CA) (Medicare Advantage PPO)	January 1, 2023
3) Ambetter by Arizona Complete Health (HMO & PPO)	January 1, 2014
4) ATRIO Health Plans (Medicare Advantage HMO & PPO)	January 1, 2023
5) HMSA (HMO, PPO & Medicare Advantage PPO)	July 1, 2013
6) Health Net (CA) (HMO & PPO)	January 1, 2014
7) Health Net Health Plan of Oregon, Inc. (EPO, HMO, POS & PPO)	July 1, 2003
8) Providence Health Plan (OR) (Signature & Choice)	July 1, 2003
9) Saint Mary's ATRIO Health Plans (Medicare Advantage PPO)	January 1, 2023
10) Sentara (formerly Optima Health) (PPO) (NC & VA)	January 1, 2005
11) Sentara (formerly Optima Health) (HMO & POS) (NC & VA)	January 1, 2007
12) Sharp Health Plan (POS & PPO)	June 1, 2021
13) Wellcare by Health Net (Medicare Advantage HMO & PPO)	July 1. 2003

American Specialty Health Group, Inc. Seamless Accounts
(Habilitative Care; Benefit Plan)

Effective 1/1/17
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: American Specialty Health Group, Inc. (ASH Group) offers and/or administers chiropractic benefits to health plans and employer groups nationwide. Under this plan, Members covered by an eligible health plan or employer group may access a Contracted Practitioner in any state. Members may be covered under a regional health plan in another state and have reciprocity when traveling nationwide, on business or personal, or Members residing outside their health plan service area, may seek services from a Contracted Practitioner. Please see Attachment D-2 to this Client Summary for a complete list of eligible health plans and employer groups.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Health care services that are provided to improve or prevent decline in a person's ability to keep, develop, learn or improve skills and functioning required for activities of daily living. Examples include services for a child with cerebral palsy who isn't walking or talking at the expected age and has not developed trunk stabilization to allow the ability to sit independently, or a child with motor apraxia who has fine motor intention tremor and has not developed fine motor skills of the hand.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may not limit this election to specific health plan clients. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: If covered, according to the "Services Fee Schedule I7" attached. (Contracted Practitioner may bill Primary Service and Adjunctive Therapy separately.)

Primary Service: If covered, according to the "Services Fee Schedule I7" attached. A Primary Service is one of the four active therapy services listed in the Fee schedule. If additional active therapy services are billed with a Primary Service, then the additional active therapy services are reimbursed at the Adjunctive Therapy fee levels. The payment amount for the Primary Service represents all services related to the Primary Services including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, service delivery and re-assessment, post-service chart documentation, consultation and reporting.

Adjunctive Therapy: If covered, according to the "Services Fee Schedule I7" attached. The Chiropractic Fee Schedule represents an all-inclusive, maximum reimbursable amount for all Adjunctive Therapy services.

Special Services: If covered, according to the "Services Fee Schedule I7" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Laboratory Services must be referred to the Member's Primary Care Physician for medical evaluation.

Supports and Appliances: Not a Covered Service.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

REHABILITATIVE AND HABILIATIVE CARE: The Patient Protection and Affordable Care Act (PPACA) requires that some plans cover habilitative care separately and to the same benefit limits as rehabilitative care. To properly manage this benefit design, it is important to ensure that care is properly identified under the benefit as either habilitative or rehabilitative. You must submit habilitative services using the "Medical Necessity Review Form Only for Habilitative Care for Chiropractic" that is available on ASHLink under Forms. Please continue to use the standard MNR Form for rehabilitative services. ASH may investigate claims billed as habilitative services if the patient presentation makes the designation as such appear inappropriate. Refer to the "Managing Habilitative Care (versus) Rehabilitative" section of the Practitioner Operations Manual for additional details.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an identification card from a health plan/employer group identified on Attachment D-2. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payment. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit a "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if a "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Attachment D-2
American Specialty Health Group, Inc. Seamless Accounts
(Habilitative Care; Benefit Plan)

LIST OF ELIGIBLE HEALTH PLANS/EMPLOYER GROUPS:	**EFFECTIVE DATES:**
1) Sentara (formerly Optima Health) (Exchange HMO, POS & PPO)	January 1, 2017

American Specialty Health Group, Inc. Seamless Accounts
(Subluxation; Benefit Plan)

Revised 9/1/23

TYPE OF PLAN/EMPLOYER: American Specialty Health Group, Inc. (ASH Group) offers and/or administers chiropractic benefits to health plans and employer groups nationwide. Under this plan, Members covered by an eligible health plan or employer group may access a Contracted Practitioner in any state. Members may be covered under a regional health plan in another state and have reciprocity when traveling nationwide, on business or personal, or Members residing outside their health plan service area, may seek services from a Contracted Practitioner. Please see Attachment D-3 to this Client Summary for a complete list of eligible health plans and employer groups.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to Subluxation as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may not limit this election to specific health plan clients. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: Not a Covered Service.

Chiropractic Manipulative Treatment: According to the "Services Fee Schedule G6" attached.

Adjunctive Therapy: Not a Covered Service.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MR, CT): Not a Covered Service.

Laboratory Services: Not a Covered Service.

Supports and Appliances: Not a Covered Service.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's annual benefit maximum, if applicable, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an identification card from a health plan/employer group identified on Attachment D-3. Contact ASH Group to verify Member's Eligibility, Benefits, and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Certain employer groups do not require the routine submission of "MNR Forms". Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Attachment D-3
American Specialty Health Group, Inc. Seamless Accounts
(Subluxation; Benefit Plan)

LIST OF ELIGIBLE HEALTH PLANS/EMPLOYER GROUPS:	EFFECTIVE DATES:
1) Aetna (Medicare Advantage HMO & PPO)	January 1, 2023
2) Alignment Healthcare (CA) (Medicare Advantage PPO)	January 1, 2023
3) ATRIO Health Plans (Medicare Advantage HMO & PPO)	January 1, 2023
4) Saint Mary's ATRIO Health Plans (Medicare Advantage PPO)	January 1, 2023

Anthem Blue Cross and Blue Shield
(Blue Direct, Blue Open Access HMO & POS, PPO, and Indemnity; Network Access Plan)

Effective 1/1/03
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Anthem Blue Cross and Blue Shield (Anthem) is a health plan offering and/or administering health benefits for Anthem Georgia members in the following Alabama counties: Barbour, Chambers, Cherokee, Cleburne, DeKalb, Henry, Houston, Jackson, Lee, Randolph, and Russell, in the following Florida counties: Baker, Columbia, Gadsden, Hamilton, Jackson, Jefferson, Leon, Madison, and Nassau, the state of Georgia, in the following North Carolina counties: Cherokee, Clay, Jackson, and Macon, in the following South Carolina counties: Abbeville, Aiken, Allendale, Anderson, Barnwell, Edgefield, Hampton, Jasper, McCormick, and Oconee, in the following Tennessee counties: Bradley, Hamilton, Marion and Polk.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions vary based on the Member's health plan benefit. Contact Client at the number listed on the back of the Member's identification card for covered conditions. Members may be eligible for a subluxation benefit and/or supplemental benefit.
CLIENT PARTICIPATION REQUIREMENTS: Contracted Practitioner may have a later effective date with Client than the effective date with ASH Group. It is recommended that Contracted Practitioner confirm eligibility as an in-network practitioner to be eligible for reimbursement.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. Contracted Practitioner agrees to accept the amount paid by Client for Covered Services, with Member Payment, if any, as payment in full, regardless of whether the amount paid by Client is greater than, or lesser than, the listed amounts in the Chiropractic Fee Schedule. Only those charges for Covered Services billed in accordance with Client's standard claims coding methodology, which may differ materially from the coding shown in the Chiropractic Fee Schedule referenced herein, will be payable. Covered Services are also subject to Client's claims payment policies. Call Client at the number listed on the Member's identification card to determine coverage, payment policies including differences between Client's payment policies and claims coding and the coding and payment amounts set out in the Chiropractic Fee Schedule referred to herein. ASH Group makes no promise or warranty that Contracted Practitioner will be paid for Covered Services in the amounts set out in the Chiropractic Fee Schedule, or in any different amount.
The specific information listed below concerning reimbursement and claims coding is for informational purposes only. For specific payment information, which may differ materially from the information contained below, contact Client.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule U3" attached. (Contracted Practitioner may bill Chiropractic Manipulative Treatment separately.)

Chiropractic Manipulative Treatment: According to the "Services Fee Schedule U3" attached. The Chiropractic Fee Schedule represents an all-inclusive maximum reimbursable amount for the Chiropractic Manipulative Treatment(s) (CMT), except Adjunctive Therapy associated with the CMT(s). When an extraspinal CMT is billed with a spinal CMT it will be included in the maximum reimbursable amount for CMT. This CMT includes all services related to the CMT(s), including a re-evaluation, and/or any consultative services.

Subluxation benefit: Member coverage is limited to a subluxation diagnosis and CPT codes 98940, 98941 and 98942.

Adjunctive Therapy: According to the "Services Fee Schedule U3" attached.

Special Services: According to the "Services Fee Schedule U3" attached.

X-Rays: According to the "X-Ray Fee Schedule Z1" attached.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Laboratory Services must be referred to the Member's Physician for medical evaluation.

Supports and Appliances: According to the "Supports and Appliances Fee Schedule J1" attached, if covered. Contracted Practitioner will be reimbursed for Services approved by Anthem Blue Cross and Blue Shield as Medically Necessary Services.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

This Fee Schedule Amount provision may differ from the Fee Schedule Amount and other provision(s) concerning reimbursement for Covered Services found in the Agreement, including its Attachments and the Operations Manual. This Fee Schedule Amount provision controls the rights and obligations of the Parties with respect to reimbursement for Covered Services.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Anthem Blue Cross and Blue Shield identification card. Go to 'ProviderAccess' at www.bcbsga.com or call the phone number listed on the Member's identification card to verify Member Eligibility and Benefits.

CLINICAL SERVICES PROGRAM: The submission of a "Medical Necessity Review Form" is not required.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner may be financially responsible for Emergent/Urgent Services rendered if requested documentation is not submitted to Client for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered. Payment for Emergent/Urgent Services is subject to Member benefits.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program incentive payments do not apply to this Client Summary as reimbursement is made by Client to Contracted Practitioner. Incentive Payment Program incentive payments are only made to Contracted Practitioner if ASH Group makes payment directly to Contracted Practitioner.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Send all claims to Client at the address listed on the Member's identification card. Claims received by Client more than ninety (90) days of the date-of-services will be denied for late submission. The Member is not financially responsible for any claims not submitted timely. Re-submittal will be denied as a duplicate unless the claim contains an adjustment or correction and is appropriately stamped "Corrected Claim." For all claims inquiries and tracers contact Client at the phone number listed on the Member's identification card.

HOLD HARMLESS: In addition to the requirements of Article 9, HOLD HARMLESS in the Chiropractic Practitioner Services Agreement, the Contracted Practitioner hereby agrees to the following: To the extent not covered by insurance, Contracted Practitioner shall be solely responsible for and shall hold Anthem Blue Cross and Blue Shield free and harmless from any claims, losses, damages, liabilities, costs, expenses, attorneys' fees and costs or obligations arising from or relating to any act or omission of Contracted Practitioner, its agents, partners, associates, employees or representatives in providing or failing to provide Chiropractic Services to Members or arising from or relating to any act or duties and obligations of Contracted Practitioner including, but not limited to, Contracted Practitioner's obligation to provide services that meet professionally recognized standards of practice.

THIRD PARTY LIABILITY: Contracted Practitioner shall accept Anthem Blue Cross and Blue Shield reimbursement for approved Chiropractic Services as payment in full. Contracted Practitioner shall not bill Member for non-approved services or for the difference between billed charges and paid charges. To the extent this Third Party Liability provision differs from any provision(s) concerning Third Party Liability found in the Agreement, including its Attachments and the Operations Manual, this Third Party Liability provision, but only this Third Party Liability provision, shall control the rights and obligations of the Parties with respect to this Client Summary only.

OTHER: Sign up for Anthem's Network eUPDATE at https://messageinsite.com/networkeupdate to receive the most up-to-date practitioner communications. Network eUPDATE provides the latest information on products and programs, medical and reimbursement, provider manual updates, newsletters and seminar invitations.

Anthem Blue Cross and Blue Shield
(HMO, HMO Open Access, POS, POS Open Access & PPO; Benefit Plan)

Effective 3/7/13
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Anthem Blue Cross and Blue Shield (Anthem) is a health plan offering and/or administering health benefits for Anthem Georgia members in the following Alabama counties: Barbour, Chambers, Cherokee, Cleburne, DeKalb, Henry, Houston, Jackson, Lee, Randolph, and Russell; the following Florida counties: Baker, Columbia, Gadsden, Hamilton, Jackson, Jefferson, Leon, Madison, and Nassau; the state of Georgia; the following North Carolina counties: Cherokee, Clay, Jackson, and Macon; the following South Carolina counties: Abbeville, Aiken, Allendale, Anderson, Barnwell, Edgefield, Hampton, Jasper, McCormick, and Oconee; and the following Tennessee counties: Bradley, Hamilton, Marion, and Polk.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions include musculoskeletal and related disorders and pain syndromes as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
CLIENT PARTICIPATION REQUIREMENTS: Contracted Practitioner may have a later effective date with Client than the effective date with ASH Group. It is recommended that Contracted Practitioner confirm eligibility as an in-network practitioner to be eligible for reimbursement.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule G8" attached. New/Established Patient Evaluation & Management is reimbursed separately from the Primary Service to provide a more extensive assessment than what is allowed within the work value associated with a Primary Service. (Contracted Practitioner may bill Primary Service separately.)

Primary Service: According to the "Services Fee Schedule G8" attached. A Primary Service is a spinal or extraspinal chiropractic manipulative treatment (CMT) or, in the absence of a CMT, an active therapy service. When an extraspinal CMT is billed with a spinal CMT it will be included in a maximum reimbursable amount for CMT. When an active therapy service is billed with a spinal or extraspinal CMT the active therapy service is reimbursed at the Adjunctive Therapy fee levels. Spinal or extraspinal CMT represents all services related to the CMT including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, manipulation and re-assessment, post-service chart documentation, consultation and reporting.

Adjunctive Therapy: According to the "Services Fee Schedule G8" attached. When billed with an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $18 per date of service. When billed without an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $24 per date of service.

Special Services: According to the "Services Fee Schedule G8" attached.

X-Rays: According to the "X-Ray Fee Schedule A" attached or refer to an ASH Group ancillary radiology provider.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Clinical Services must be referred to the Member's Physician for medical evaluation.

Supports and Appliances: According to the "Supports and Appliances Fee Schedule W2" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Anthem Blue Cross and Blue Shield identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described above and in the "Clinical Performance System" section of your Practitioner Operations Manual. CPT codes for Active Therapy (97110, 97140 and 97530) are also included under the Clinical Performance System for this Client.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

THIRD PARTY LIABILITY: Contracted Practitioner shall accept Anthem Blue Cross and Blue Shield reimbursement for approved Chiropractic Services as payment in full. Contracted Practitioner shall not bill Member for non-approved services or for the difference between billed charges and paid charges. To the extent this Third Party Liability provision differs from any provision(s) concerning Third Party Liability found in the Agreement, including its Attachments and the Operations Manual, this Third Party Liability provision, but only this Third Party Liability provision, shall control the rights and obligations of the Parties with respect to this Client Summary only.

OTHER: Sign up for Anthem's Network eUPDATE at https://messageinsite.com/networkeupdate to receive the most up-to-date practitioner communications. Network eUPDATE provides the latest information on products and programs, medical and reimbursement, provider manual updates, newsletters and seminar invitations.

Ascension Complete
(Medicare Advantage HMO; Benefit Plan)

Effective 2/1/23
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Ascension Complete is a health plan offering and/or administering health benefits in Florida.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Subluxation as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: Not a Covered Service.
Chiropractic Manipulative Treatment: According to the "Services Fee Schedule D4" attached.
Adjunctive Therapy: Not a Covered Service.
X-Rays: Not a Covered Service.
Diagnostic Imaging (MR, CT): Not a Covered Service.
Laboratory Services: Not a Covered Service.
Supports and Appliances: Not a Covered Service.
Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's annual benefit maximum, if applicable, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Ascension Complete identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described above and in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Centivo
(Benefit Plan)
Effective 1/1/22
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Centivo is a third-party administrator (TPA) administering health benefits to self-funded employer groups in California, Colorado, Connecticut, Florida, Iowa, Michigan, Missouri, Nebraska, New Jersey, New York, Pennsylvania, Washington, and Wisconsin.
PLACE OF SERVICE: Client offers in-office and telehealth services. Telehealth services must be appropriate for delivery via telehealth platform for synchronous or asynchronous care delivery.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions include musculoskeletal and related disorders and pain syndromes as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adapted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule R10" attached. New/Established Patient Evaluation & Management is reimbursed separately from the Primary Service to provide a more extensive assessment than what is allowed within the work value associated with a Primary Service. (Contracted Practitioner may bill Primary Service separately.)

Primary Service: According to the "Services Fee Schedule R10" attached. A Primary Service is a spinal or extraspinal chiropractic manipulative treatment (CMT) or, in the absence of a CMT, an active therapy service. When an extraspinal CMT is billed with a spinal CMT it will be included in a maximum reimbursable amount for CMT. When an active therapy service is billed with a spinal CMT or extraspinal CMT the active therapy service is reimbursed at the Adjunctive Therapy fee levels. Spinal or extraspinal CMT represents all services related to the CMT including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, manipulation and re-assessment, post-service chart documentation, consultation and reporting.

Adjunctive Therapy: According to the "Services Fee Schedule R10" attached. When billed with an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $18 per date of service. When billed without an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $24 per date of service.

Special Services: According to the "Services Fee Schedule R10" attached.

X-Rays: According to the "X-Ray Fee Schedule I4" attached or refer to an ASH Group ancillary radiology provider.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: All Laboratory Services must be referred to an ASH Group ancillary laboratory provider.

Supports and Appliances: According to the "Supports and Appliances Fee Schedule R2" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Centivo identification card. Contact ASH Group to verify Member's Eligibility, Benefits, and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described above and in the "Clinical Performance System" section of your Practitioner Operations Manual. CPT codes for Active Therapy (97110, 97140 and 97530) are also included under the Clinical Performance System for this Client.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

ChooseHealthy Program

Revised 9/1/22

The ChooseHealthy Program provides discounts for Chiropractic Services to Members from Contracted Practitioner. The ChooseHealthy Program is not insurance. ChooseHealthy Members should check any health insurance benefits before using this discount program, as those benefits may result in lower costs. The ChooseHealthy program is provided by American Specialty Health Group, Inc. and ASH Technologies, Inc. (dba ASH Technologies of Delaware, Inc. in the state of Pennsylvania); all are subsidiaries of American Specialty health Incorporated (ASH), a national provider of fitness, health education, musculoskeletal provider networks, and health management programs.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate in the ASH Group ChooseHealthy Program. If Contracted Practitioner chooses to not participate with this Client Summary, Contracted Practitioner may not limit this election to specific clients.

STATE SPECIFIC MALPRACTICE LIMITS: Refer to Attachment I Section II of the Agreement for state specific malpractice limit requirements.

CALCULATING REQUIRED DISCOUNT: The Contracted Practitioner must charge the Member the lower of the following:

a) 25% off Contracted Practitioner's usual and customary fee schedule, or

b) The fees listed in the attached "ChooseHealthy Program Maximum Fee Schedule."

Any service within Contracted Practitioner's scope of practice, but not listed on the ChooseHealthy Program Fee Schedule, would default to 25% off the Contracted Practitioner's usual & customary rate.

MEMBER ELIGIBILITY: Members will present a ChooseHealthy Discount Certificate. Any Member who presents a ChooseHealthy Discount Certificate is eligible for this ChooseHealthy Program. Contracted Practitioner should not contact ASH Group to verify Member eligibility, as ASH Group does not maintain eligibility information for the ChooseHealthy Program. ChooseHealthy Discount Certificates are available to members through the *Find a Provider* search on ChooseHealthy.com.

CLINICAL SERVICES PROGRAM: The Clinical Services Program and verification of Medical Necessity do not apply to this program.

CLAIMS: There are no claims to be submitted to ASH Group. Member is responsible to pay Contracted Practitioner for all Chiropractic Services according to the Calculating Required Discount section above.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program does not apply to this Client Summary as the transactions included under the Incentive Payment Program are not applicable to the ChooseHealthy Program.

Cigna Healthcare
(Benefit Plan)

Effective 7/1/13
Revised 12/1/32

TYPE OF PLAN/EMPLOYER: Cigna Healthcare is a health plan offering and/or administering health benefits in Florida.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions include musculoskeletal and related disorders and pain syndromes as defined in the "Covered Conditions" section of the Practitioner Operations Manual.
CLIENT PARTICIPATION REQUIREMENTS: Contracted Practitioner must have executed agreements with both ASH Group and Client to be eligible for any ChooseHealthy Program or chiropractic benefit plan.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. Call Client at the number listed on the Member's identification card to determine coverage, payment policies including differences between Client's payment policies and claims coding and the coding and payment amounts set out in the Chiropractic Fee Schedule referred to herein. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
The specific information listed below concerning reimbursement and claims coding is for informational purposes only. For specific payment information, which may differ materially from the information contained below, contact Client.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule B6" attached. New/Established Patient Evaluation & Management is reimbursed separately from the Primary Service to provide a more extensive assessment than what is allowed within the work value associated with a Primary Service. (Contracted Practitioner may bill Primary Service separately.)

Primary Service: According to the "Services Fee Schedule B6" attached. A Primary Service is a spinal or extraspinal chiropractic manipulative treatment (CMT) or, in the absence of a CMT, an active therapy service or acupuncture service. When an extraspinal CMT is billed with a spinal CMT it will be included in a maximum reimbursable amount for CMT. When an active therapy or acupuncture service is billed with a spinal or extraspinal CMT the active therapy or acupuncture service is reimbursed at the Adjunctive Therapy fee levels. Acupuncture services are not covered for all Members; only eligible Members are covered for acupuncture services. Spinal or extraspinal CMT represents all services related to the CMT including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, manipulation and re-assessment, post-service chart documentation, consultation and reporting.

Adjunctive Therapy: According to the "Services Fee Schedule B6" attached. When billed with an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $18 per date of service. When billed without an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $24 per date of service. Acupuncture and therapeutic massage services are not covered for all Members; only eligible Members are covered for acupuncture and therapeutic massage services.

Special Services: According to the "Services Fee Schedule B6" attached.

X-Rays: According to the "X-Ray Fee Schedule M2" attached or refer to a Cigna Healthcare Contracted Facility.

Diagnostic Imaging (MRI, CAT Scans): All Diagnostic Imaging Services must be referred to a Cigna Healthcare Contracted Facility.

Laboratory Services: All Laboratory Services must be referred to a Cigna Healthcare Contracted Facility.

Supports and Appliances: According to the "Supports and Appliances Fee Schedule G2" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Cigna Healthcare identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLAIMS-BASED REIMBURSEMENT: Benefit plans administered by ASH Group for Client may include reimbursement of ASH Group services utilizing a claims-based reimbursement methodology. Under the claims based reimbursement methodology, Client and ASH Group have agreed upon and established a separate Client – ASH Group Fee Schedule. The Client – ASH Group Fee Schedule includes the Fee Schedule amounts in effect between ASH Group and Contracted Practitioner plus an allocation for ASH Group's care coordination, clinical integration, and administrative services that have been delegated by Client. Upon payment to ASH Group by Client, for clinical services that are determined to Medically Necessary Services, ASH Group shall reimburse Contracted Practitioner in accordance with the Fee Schedules in effect between ASH Group and Contracted Practitioner, less any Member out-of-pocket expense. ASH Group will retain any remaining portion of payment by Client as reimbursement for ASH Group's care coordination, clinical integration and administrative services provided to Client. ASH Group shall identify the Member Out-of-Pocket expense Contracted Practitioner is permitted to collect and any payment made by ASH Group for Medically Necessary Services for Covered Conditions.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Certain employer groups may not require the routine submission of "MNR Forms" or may have a specific visit limit allowance before submission is required. Contracted Practitioner is not required to submit for medical necessity review until they exhaust the number of visits under the Client specific visit allowance or they reach their Clinical Performance System waiver visit limit, whichever is greater. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described above and in the "Clinical Performance System" section of your Practitioner Operations Manual. CPT codes for Active Therapy (97110, 97140 and 97530) and Acupuncture (97810 and 97813) are also included under the Clinical Performance System for this Client.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit administrative "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details. Submit clinical "Appeals and Grievances" to Cigna Healthcare National Appeals Unit (NAO), P.O. Box 188011, Chattanooga, TN 37422 for Cigna Healthcare East Members and to Cigna Healthcare Appeals & Grievances, P.O. Box 668, Kennett, MO, 63857 for Cigna Healthcare West members.

Florida Blue
(Benefit Plan)
Effective 4/1/15
Revised 12/1/23

TYPE OF PLAN/EMPLOYER: Florida Blue is a health plan offering and/or administering health benefits in the following Alabama counties: Baldwin, Covington, Escambia, Geneva, and Houston, the state of Florida, and the following Georgia counties: Brooks, Camden, Charlton, Clinch, Decatur, Echols, Grady, Lowndes, Seminole, Thomas, and Ware. The following Florida Blue members may be eligible under this Benefit Plan: Blue Care HMO, Blue Options, Blue PPO (including Federal Employee Program Members), BlueSelect, and Miami-Dade Blue. Out-of-state EPO members and ICUBA members seeking services in Florida are covered under the Fee Schedule listed below. Claims are managed by Florida Blue. All medical necessity review, and eligibility and benefits are coordinated through the member's Home Plan.

Federal Employee Program and State Account Members: Members have access in the state of Florida only.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered conditions include musculoskeletal and related disorders and pain syndromes as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

CLIENT PARTICIPATION REQUIREMENTS: Contracted Practitioner must have a Florida Board of Chiropractic Medicine license to treat a Florida Blue Member. Contracted Practitioners who participate with Florida Blue are required to register an account through Availity; the secure online portal utilized by Florida Blue.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner is also choosing to not participate in all Client Summaries offered by both Florida Blue and Truli for Health. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements. The provisions in Attachment D-4 apply to Contracted Practitioners who provide services to members enrolled in Florida Blue.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

Evaluation & Management/Consultation: According to the "Services Fee Schedule R6" attached. Evaluation & Management/Consultation is reimbursed separately from the Primary Service to provide a more extensive assessment than what is allowed within the work value associated with a Primary Service. (Contracted Practitioner may bill Primary Service separately.)

Primary Service: According to the "Services Fee Schedule R6" attached. A Primary Service is a spinal or extraspinal chiropractic manipulative treatment (CMT) or, in the absence of a CMT, an active therapy service or acupuncture service. When an extraspinal CMT is billed with a spinal CMT it will be included in a maximum reimbursable amount for CMT. When an active therapy or acupuncture service is billed with a spinal or extraspinal CMT the active therapy or acupuncture service is reimbursed at the Adjunctive Therapy fee levels. Spinal or extraspinal CMT represents all services related to the CMT including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, manipulation and re-assessment, post-service chart documentation, consultation and reporting.

Adjunctive Therapy: According to the "Services Fee Schedule R6" attached. When billed with an Evaluation & Management/Consultation or Primary Service, Adjunctive Therapy will be reimbursed up to $18 per date of service. When billed without an Evaluation & Management/Consultation or Primary Service, Adjunctive Therapy will be reimbursed up to $24 per date of service. Some employer groups have a benefit limit of one (1) adjunctive therapy unit when a Chiropractic Manipulative Therapy (CPT codes 98940-98943) is billed and a limit of four (4) adjunctive therapy units when a Chiropractic Manipulative Therapy is not billed.

Special Services: According to the "Services Fee Schedule R6" attached.

Laboratory Services: According to the "Services Fee Schedule R6" attached or refer to a Quest Diagnostics laboratory practitioner. Quest Diagnostics laboratory practitioner can bill Florida Blue directly for laboratory services not covered in this Client Summary.

X-Rays: According to the "X-Ray Fee Schedule F3" attached or refer to an ASH Group ancillary radiology provider.

Diagnostic Imaging (MRI, CAT Scans): All Diagnostic Imaging Services can be referred to a Florida Blue Contracted Facility.

Supports and Appliances: Not a Covered Service.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Florida Blue identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Certain employer groups do not require the routine submission of "MNR Forms". Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described above and in the "Clinical Performance System" section of your Practitioner Operations Manual. CPT codes for Active Therapy (97110, 97140, 97530 and 97535) and Acupuncture (97810 and 97813) are also included under the Clinical Performance System for this Client.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Florida Blue
City of Jacksonville
(Benefit Plan)

Effective 5/1/15
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Florida Blue is a health plan offering and/or administering health benefits for City of Jacksonville employees in the following Alabama counties: Baldwin, Covington, Escambia, Geneva, and Houston, the state of Florida, and the following Georgia counties: Brooks, Camden, Charlton, Clinch, Decatur, Echols, Grady, Lowndes, Seminole, Thomas, and Ware. The following Florida Blue members may be eligible under this Benefit Plan: Blue Care HMO, Blue Options, BlueSelect, and Miami-Dade Blue. Out-of-state EPO members and ICUBA members seeking services in Florida are covered under the Fee Schedule listed below. Claims are managed by Florida Blue. All medical necessity review, and eligibility and benefits are coordinated through the member's Home Plan.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered conditions include musculoskeletal and related disorders and pain syndromes as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

CLIENT PARTICIPATION REQUIREMENTS: Contracted Practitioner must have a Florida Board of Chiropractic Medicine license to treat a Florida Blue Member. Contracted Practitioners who participate with Florida Blue are required to register an account through Availity; the secure online portal utilized by Florida Blue.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner is also choosing to not participate in all Client Summaries offered by both Florida Blue and Truli for Health. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements. The provisions in Attachment D-4 apply to Contracted Practitioners who provide services to members enrolled in Florida Blue.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

Evaluation & Management/Consultation: According to the "Services Fee Schedule R6" attached. Evaluation & Management/Consultation is reimbursed separately from the Primary Service to provide a more extensive assessment than what is allowed within the work value associated with a Primary Service. (Contracted Practitioner may bill Primary Service separately.)

Primary Service: According to the "Services Fee Schedule R6" attached. A Primary Service is a spinal or extraspinal chiropractic manipulative treatment (CMT) or, in the absence of a CMT, an active therapy service or acupuncture service. When an extraspinal CMT is billed with a spinal CMT it will be included in a maximum reimbursable amount for CMT. When an active therapy or acupuncture service is billed with a spinal or extraspinal CMT the active therapy or acupuncture service is reimbursed at the Adjunctive Therapy fee levels. Spinal or extraspinal CMT represents all services related to the CMT including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, manipulation and re-assessment, post-service chart documentation, consultation and reporting.

Adjunctive Therapy: According to the "Services Fee Schedule R6" attached. When billed with an Evaluation & Management/Consultation or Primary Service, Adjunctive Therapy will be reimbursed up to $18 per date of service. When billed without an Evaluation & Management/Consultation or Primary Service, Adjunctive Therapy will be reimbursed up to $24 per date of service. Therapeutic massage services (CPT code 97124) are eligible for separate reimbursement up to $72 per date of service.

Special Services: According to the "Services Fee Schedule R6" attached.

Laboratory Services: According to the "Services Fee Schedule R6" attached or refer to a Quest Diagnostics laboratory practitioner. Quest Diagnostics laboratory practitioner can bill Florida Blue directly for laboratory services not covered in this Client Summary.

X-Rays: According to the "X-Ray Fee Schedule F3" attached or refer to an ASH Group ancillary radiology provider.

Diagnostic Imaging (MRI, CAT Scans): All Diagnostic Imaging Services can be referred to a Florida Blue Contracted Facility.

Supports and Appliances: Not a Covered Service.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not. Therapeutic massage services (CPT code 97124) are included in the Member's medical outpatient rehabilitation services covered up to 60 visits per calendar year. Chiropractic manipulative therapy (CPT codes 98940-98943) services are covered up to 20 visits per calendar year. Physical medicine therapy, excluding therapeutic massage services (CPT code 97124), are unlimited.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Florida Blue identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details. When a member receives Chiropractic Manipulative Therapy (CPT codes 98940-98943) and a therapeutic massage (CPT code 97124) on the same day, member will pay one copayment for that date of service. If a member reaches their visit maximum contracted practitioner can bill for other covered services.

CLINICAL SERVICES PROGRAM: The submission of a "Medical Necessity Review Form is not required under this program. Medical Records review may be required on some cases.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner may be financially responsible for Emergent/Urgent Services rendered if requested documentation is not submitted to Client for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Florida Blue
(Medicare Advantage HMO & PPO; Benefit Plan)

Effective 4/1/15
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Florida Blue is a health plan offering and/or administering health benefits in the following Alabama counties: Baldwin, Covington, Escambia, Geneva, and Houston, the state of Florida, and the following Georgia counties: Brooks, Camden, Charlton, Clinch, Decatur, Echols, Grady, Lowndes, Seminole, Thomas, and Ware.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to Subluxation as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

CLIENT PARTICIPATION REQUIREMENTS: Contracted Practitioner must have a Florida Board of Chiropractic Medicine license to treat a Florida Blue Member. Contracted Practitioners who participate with Florida Blue are required to register an account through Availity; the secure online portal utilized by Florida Blue.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner is also choosing to not participate in all Client Summaries offered by both Florida Blue and Truli for Health. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements. The provisions in Attachment D-4 apply to Contracted Practitioners who provide services to members enrolled in Florida Blue.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: Not a Covered Service.

Chiropractic Manipulative Treatment: According to the "Services Fee Schedule Q6" attached.

Adjunctive Therapy: Not a Covered Service.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MR, CT): Not a Covered Service.

Laboratory Services: Not a Covered Service. Laboratory Services can be referred to a Quest Diagnostics laboratory practitioner. Quest Diagnostics laboratory practitioner can bill Florida Blue directly for any laboratory services provided.

Supports and Appliances: Not a Covered Service.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's annual benefit maximum, if applicable, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Florida Blue identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Attachment D-4
Florida Blue
Practitioner Services Agreement Amendment

The following Amendments to the Chiropractic Practitioner Services Agreement are required for participation in the Florida Blue Client Summary:

1. **Section 3.27 Non-Discrimination against Chiropractors and Members** is replaced in its entirety to read as follows: ASH Group and/or its affiliates shall not discriminate against practitioners and/or Members for any reason, including but not limited to age, sex, marital status, religion, ethnic background, national origin, veteran status, political beliefs or affiliations, ancestry, race, color, sexual orientation, gender identity, health disability status or source or amount of reimbursement. ASH Group and/or its affiliates are prohibited from discriminating with respect to reimbursement, participation or indemnification against Contracted Practitioners who service high risk populations or who specialize in the treatment of costly conditions as long as the Contracted Practitioner is acting within the scope of practice.
2. **Section 4.28 Non Discrimination** is replaced in its entirety to read as follows: Contracted Practitioner shall comply with applicable state and federal laws and regulations regarding non-discrimination. Contracted Practitioner shall not discriminate against Members, employees or applicants for employment for any reason, including but not limited to age, sex, marital status, religion, ethnic background, national origin, veteran status, political beliefs or affiliations, ancestry, race, color, sexual orientation, gender identity, health disability status or source or amount of reimbursement. Contracted Practitioner shall render Covered Services and/or ChooseHealthy Services to Members covered by a Client Benefit Plan and/or ChooseHealthy Program in the same manner, in accordance with the same standards, and within the same time availability as services offered to patients who are not Members.
3. **Section 5.07 (a)** is replaced in its entirety to read as follows: receiving notice of intent to file or actual filing of any claims for professional negligence or malpractice against Contracted Practitioner or the institution of any action, litigation or lawsuit in that regard, regardless of whether the claim involves a Member;
4. **Section 4.11, Appeal Rights** is amended to add a new subsection (c) to read as follows: Cooperation with Member Grievance and Appeal Resolution Process. Contracted Practitioner acknowledges that Florida Blue, pursuant to their various agreements with groups and individuals to provide prepaid health care and as required by Federal and State agencies and pursuant to Laws, has established a grievance resolution and appeal procedure that provides a meaningful process for hearing and resolving disputes involving Members, Florida Blue and/or providers. Contracted Practitioner agrees: (i) that any complaint, grievance or claim asserted pursuant to such grievance resolution and appeal procedure shall be resolved in accordance with such grievance resolution and appeal procedure; (ii) to comply with reasonable requests from Florida Blue to assist in resolving such disputes; (iii) will comply with all final determinations; and (iv) fully cooperate with all grievance, appeal and coverage determinations processes required by Florida Blue and pursuant to Laws. Contracted Practitioner acknowledges that Florida Blue may delegate certain aspects of any required grievances and appeals processes to ASH Group.
5. **Article 9. Hold Harmless** is amended to add two new sections to read as follows:

   9.02 Florida Blue shall not be responsible for any act, omission, or default of Contracted Practitioner or any officer, director, employee, agent, subcontractor or representative of the Contracted Practitioner or for any negligence, misfeasance, malfeasance or nonfeasance of Contracted Practitioner or any officer, director, employee, agent, subcontractor or representative of the Contracted Practitioner.

   9.03 Florida Blue shall not be responsible for any material violation of any applicable privacy law or regulations for wrongful use or disclosure of information collected from or about Members by Contracted Practitioner or any officer, director, employee, agent, subcontractor or representative of Contracted Practitioner.
6. **Section 4.30 Sharing of Contracted Practitioner's Data and Information:** Florida Blue requires ASH Group to require all Contracted Practitioners providing Services to Florida Blue members to agree to comply with the requirements of this *Sharing of Contracted Practitioner's Data and Information* section. This requirement applies to any and all past, current and future data and information as further described below. Your provision of Services to Florida Blue members constitutes your continued acceptance of, and your agreement to comply with, the following: Contracted Practitioner agrees that, notwithstanding any other provisions in this Attachment D Client Summary, the Practitioner Services Agreement, or the ASH Group Operations Manual, and subject to applicable laws and regulations, ASH Group may release to Florida Blue, and Florida Blue may further use and may further release, information and/or data pertaining to Contracted Practitioner that Florida Blue reasonably deems relevant and important for Florida Blue purposes, including without limitation: biographical and demographic information and data; information and data submitted or collected in connection with participation in the ASH Group Chiropractic Provider Network for Florida Blue; survey data; utilization information; quality of care measures and initiatives; service volumes; credentialing information; outcome measures; patient satisfaction results; accessibility and overall satisfaction with encounter experience(s); cost data; and such other health care related data generated or collected in connection with this Attachment D Client Summary, the Practitioner Services Agreement, or the ASH Group Operations Manual (collectively "Health Care Data"). Contracted Practitioner acknowledges and agrees that such Health Care Data may be released by ASH Group, or any of its affiliates, to Florida Blue, and further used and released by Florida Blue, or any of its affiliates, for any purpose not prohibited by law, regulation, order, decree, instructions, guidance or requirements of any governmental or quasi-governmental authority having jurisdiction over this Attachment D Client Summary, the Practitioner Services Agreement, or the ASH Group Operations Manual (including, but not limited to, opinions issued by the Florida Department of Insurance) including without limitation allowing Florida Blue members, employer groups, providers, ASH Group, and others to relatively compare the cost and level of quality of care.

6. **Section 4.30 Sharing of Contracted Practitioner's Data and Information (Cont.):** Florida Blue may share Health Care Data via Florida Blue's website or by other means as determined by Florida Blue. Furthermore, Contracted Practitioner agrees to provide to ASH Group, or directly to Florida Blue if requested, any Health Care Data related to the Services provided, as reasonably requested by ASH Group or Florida Blue. For purposes of this section, "Services" is defined as (i) those management and/or administrative services that Contracted Practitioner provides pursuant to this Attachment D Client Summary, the Practitioner Services Agreement, or the ASH Group Operations Manual and (ii) those chiropractic clinical services (e.g. chiropractic physical medicine modalities and procedures such as chiropractic manipulation and massage, etc.) and related management and administrative services provided by a Contracted Practitioner pursuant to this Attachment D Client Summary, the Practitioner Services Agreement, or the ASH Group Operations Manual. Contracted Practitioner represents and warrants that he/she has the legally necessary authority to agree to the use of Health Care Data used by Contracted Practitioner in the provision of Services hereunder. Florida Blue shall review and consider in good faith any detailed, written response by Contracted Practitioner claiming that any Health Care Data used by Florida Blue is materially inaccurate and will work with Contracted Practitioner to correct any such materially inaccurate Health Care Data.
7. **Attachment E.** A new section 28 is added to Attachment E, to read as follows: 28. Provider shall not send claims data, store claims or populate claims of Medicare Member information outside of the United States of America or its territories also known as Offshore and/or Off-Shoring.
8. **Attachment I. Professional Liability Insurance Limits** is replaced in its entirety to read as follows: Contracted Practitioner shall maintain professional liability (malpractice) insurance in an amount, which is the greater of: (a) the minimum amount required by State law; or (b) Two Hundred Fifty Thousand Dollars ($250,000) per claim and Seven Hundred Fifty Thousand Dollars ($750,000) in the aggregate per year.

NOTE: This Client Summary is subject to change pending finalization of the agreement between Florida Blue and ASH Group. Any changes will be communicated in an updated Client Summary that will include Florida Blue specific provisions and obligations.

Healthfirst
(Medicare Advantage PPO; Benefit Plan)
Effective 1/1/23
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Healthfirst is a health plan offering and/or administering health benefits to their New York members in Florida.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Subluxation as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: Not a Covered Service.
Chiropractic Manipulative Treatment: According to the "Services Fee Schedule D4" attached.
Adjunctive Therapy: Not a Covered Service.
X-Rays: Not a Covered Service.
Diagnostic Imaging (MR, CT): Not a Covered Service.
Laboratory Services: Not a Covered Service.
Supports and Appliances: Not a Covered Service.
Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's annual benefit maximum, if applicable, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Healthfirst identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described above and in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Providence Health Plan
(Signature, Choice, Connect, Extend, PEBB & Intel Connected Care; Network Access Plan)

Effective 1/1/03
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Providence Health Plan is a health plan offering and/or administering health benefits nationwide.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are those within Contracted Practitioner's scope of practice, training, competency and Client's benefit design.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. Contracted Practitioner agrees to accept the amount paid by Client for Covered Services, with Member Payment, if any, as payment in full, regardless of whether the amount paid by Client is greater than, or lesser than, the listed amounts in the Fee Schedule referenced below. Only those charges for Covered Services billed in accordance with Client's standard claims coding methodology, which may differ materially from the coding shown in the Fee Schedule referenced herein, will be payable. Covered Services are also subject to Client's claims payment policies. Call Client at the number listed on the Member's identification card to determine coverage, payment policies including differences between Client payment policies and claims coding and the coding and payment amounts set out in the Fee Schedule referred to herein. ASH Group makes no promise or warranty that Contracted Practitioner will be paid for Covered Services in the amounts set out in the Fee Schedule referenced below, or in any different amount.
The specific information listed below concerning reimbursement and claims coding is for informational purposes only. For specific payment information, which may differ materially from the information contained below, contact Client.
Reimbursement under this Client Summary shall be the lesser of:

Signature, Choice, Connect & Extend:

(a) billed charge, or;
(b) charge based on the 2016 year RBRVS unit value for the appropriate CPT code using a $50.00 conversion factor

PEBB & Intel Connected Care:

(a) billed charge, or;
(b) charge based on the 2016 year RBRVS unit value for the appropriate CPT code using a $43.50 conversion factor

The RVUs will be based on place of service and will not be geographically adjusted. For laboratory services, the fee schedule is based upon the Medicare Clinical Diagnostic Laboratory Fee Schedule available as of December 31, 2015. Allowed charges will be calculated, according to the applicable fee schedule, or billed charges, whichever is less. New codes not included in the existing fee schedules may be evaluated and priced by Health Plan applying the most current published fee schedule rates, weights or RVUs. Service codes not encompassed by fee schedules may be priced at Health Plan's discretion by applying a most comparable rate. The most current code sets will be recognized by Health Plan in accordance with HIPAA regulations. Services lacking a relative value weight, an established price, or Health Plan determined rate, will be paid at 75% of billed charges.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Providence Health Plan identification card. Call the telephone number listed on Member's identification card to verify Member eligibility and benefits.

CLINICAL SERVICES PROGRAM: The submission of a "Medical Necessity Review Form is not required.

CLIENT REQUIREMENT: Contracted Practitioner shall support the administration of Providence Health Plan's Quality and Medical Management Program and shall follow Providence Health Plan's claims policies and procedures. Contracted Practitioner may obtain a copy of or electronic access to Providence Health Plan's policies and procedures by calling their Provider Relations Representative at 800.878.4445.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner may be financially responsible for Emergent/Urgent Services rendered if requested documentation is not submitted to Client for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program incentive payments do not apply to this Client Summary as reimbursement is made by Client to Contracted Practitioner. Incentive payments are only made to Contracted Practitioner if ASH Group makes payment directly to Contracted Practitioner.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Send all claims to the address indicated on the back of the Member's identification card. Claims received by Client more than one (1) year after the date-of-service will be denied for late submission. The Member is not financially responsible for any claims not submitted timely. For all claims inquiries and tracers contact Client at the phone number listed on the Member's identification card.

Simply Healthcare Plans, Inc.
Clear Health Alliance
(Florida Healthy Kids (SCHIP) & Medicaid MMA; Medicaid Benefit Plan)

Effective 6/1/21
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Simply Healthcare Plans, Inc. and Clear Health Alliance are health plans offering and/or administering health benefits to Florida Healthy Kids State Children's Health Insurance Program (SCHIP) and Statewide Medicaid Managed Care Managed Medical Assistance Managed Medical Assistance (SMMC MMA) members in Florida.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions include musculoskeletal and related disorders and pain syndromes as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
CLIENT PARTICIPATION REQUIREMENTS: Contracted Practitioner is required to be enrolled with Medicaid to be eligible to receive reimbursement for services rendered to Medicaid Members.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that a Contracted Practitioner must be enrolled with Medicaid, to be eligible for reimbursement for services rendered to ASH Group Members under a Medicaid plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule G8" attached. New/Established Patient Evaluation & Management is reimbursed separately from the Primary Service to provide a more extensive assessment than what is allowed within the work value associated with a Primary Service. (Contracted Practitioner may bill Primary Service separately.)

Primary Service: According to the "Services Fee Schedule G8" attached. A Primary Service is a spinal or extraspinal chiropractic manipulative treatment (CMT) or, in the absence of a CMT, an active therapy service. When an extraspinal CMT is billed with a spinal CMT it will be included in a maximum reimbursable amount for CMT. When an active therapy service is billed with a spinal or extraspinal CMT the active therapy service is reimbursed at the Adjunctive Therapy fee levels. Spinal or extraspinal CMT represents all services related to the CMT including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, manipulation and re-assessment, post-service chart documentation, consultation and reporting.

Adjunctive Therapy: According to the "Services Fee Schedule G8" attached. When billed with an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $18 per date of service. When billed without an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $24 per date of service.

Special Services: According to the "Services Fee Schedule G8" attached.

X-Rays: According to the "X-Ray Fee Schedule P1" attached or refer to an ASH Group ancillary radiology provider.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: All Laboratory Services must be referred to an ASH Group ancillary laboratory provider.

Supports and Appliances: According to the "Supports and Appliances Fee Schedule O3" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Simply Healthcare Plans, Inc. and/ or Clear Health Alliance identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: The submission of a "Medical Necessity Review Form" is not required.

CLINICAL PERFORMANCE SYSTEM: ASH Group Clinical Performance System does not apply.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner may be financially responsible for Emergent/Urgent Services rendered if requested documentation is not submitted to Client for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Simply Healthcare Plans, Inc.
(Medicare Advantage HMO & PPO; Benefit Plan)

Effective 8/1/21
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Simply Healthcare Plans, Inc. is a health plan offering and/or administering health benefits in Florida.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Members may be eligible for a subluxation benefit and/or supplemental benefit. Under the supplemental benefit covered conditions include musculoskeletal and related disorders and pain syndromes. The covered conditions are further defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

Medicare Advantage HMO members may be eligible for a subluxation benefit and/or supplemental benefit.

Medicare Advantage PPO members are eligible for a subluxation benefit.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule G8" attached. New/Established Patient Evaluation & Management is reimbursed separately from the Primary Service to provide a more extensive assessment than what is allowed within the work value associated with a Primary Service. (Contracted Practitioner may bill Primary Service separately.)

Primary Service: According to the "Services Fee Schedule G8" attached. A Primary Service is a spinal or extraspinal chiropractic manipulative treatment (CMT) or, in the absence of a CMT, an active therapy service. When an extraspinal CMT is billed with a spinal CMT it will be included in a maximum reimbursable amount for CMT. When an active therapy service is billed with a spinal or extraspinal CMT the active therapy service is reimbursed at the Adjunctive Therapy fee levels. Spinal or extraspinal CMT represents all services related to the CMT including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, manipulation and re-assessment, post-service chart documentation, consultation and reporting.

Subluxation benefit: Member coverage is limited to a subluxation diagnosis and CPT codes 98940, 98941 and 98942.

Adjunctive Therapy: According to the "Services Fee Schedule G8" attached. When billed with an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $18 per date of service. When billed without an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $24 per date of service.

Special Services: According to the "Services Fee Schedule G8" attached.

X-Rays: According to the "X-Ray Fee Schedule P1" attached or refer to an ASH Group ancillary radiology provider.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: All Laboratory Services must be referred to an ASH Group ancillary laboratory provider.

Supports and Appliances: According to the "Supports and Appliances Fee Schedule W2" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Simply Healthcare Plans, Inc. identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described above and in the "Clinical Performance System" section of your Practitioner Operations Manual. CPT codes for Active Therapy (97110, 97140 and 97530) are also included under the Clinical Performance System for this Client.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Truli for Health
(HMO; Benefit Plan)

Effective 7/1/20
Revised 9/1/23

TYPE OF PLAN/EMPLOYER: Truli for Health is a health plan offering and/or administering health benefits in Florida.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions include musculoskeletal and related disorders and pain syndromes as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner is also choosing to not participate in all Client Summaries offered by both Florida Blue and Truli for Health. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

Evaluation & Management/Consultation: According to the "Services Fee Schedule R6" attached. Evaluation & Management/Consultation is reimbursed separately from the Primary Service to provide a more extensive assessment than what is allowed within the work value associated with a Primary Service. (Contracted Practitioner may bill Primary Service separately.)

Primary Service: According to the "Services Fee Schedule R6" attached. A Primary Service is a spinal or extraspinal chiropractic manipulative treatment (CMT) or, in the absence of a CMT, an active therapy service or acupuncture service. When an extraspinal CMT is billed with a spinal CMT it will be included in a maximum reimbursable amount for CMT. When an active therapy or acupuncture service is billed with a spinal or extraspinal CMT the active therapy or acupuncture service is reimbursed at the Adjunctive Therapy fee levels. Spinal or extraspinal CMT represents all services related to the CMT including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, manipulation and re-assessment, post-service chart documentation, consultation, and reporting.

Adjunctive Therapy: According to the "Services Fee Schedule R6" attached. When billed with an Evaluation & Management/Consultation or Primary Service, Adjunctive Therapy will be reimbursed up to $18 per date of service. When billed without an Evaluation & Management/Consultation or Primary Service, Adjunctive Therapy will be reimbursed up to $24 per date of service. Some employer groups have a benefit limit of one (1) adjunctive therapy unit when a Chiropractic Manipulative Therapy (CPT codes 98940-98943) is billed and a limit of four (4) adjunctive therapy units when a Chiropractic Manipulative Therapy is not billed.

Special Services: According to the "Services Fee Schedule R6" attached.

Laboratory Services: According to the "Services Fee Schedule R6" attached or refer to a Quest Diagnostics laboratory practitioner. Quest Diagnostics laboratory practitioner can bill Truli for Health directly for laboratory services not covered in this Client Summary.

X-Rays: According to the "X-Ray Fee Schedule F3" attached or refer to an ASH Group ancillary radiology provider.

Diagnostic Imaging (MRI, CAT Scans): All Diagnostic Imaging Services can be referred to a Truli for Health Contracted Facility.

Supports and Appliances: Not a Covered Service.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Truli for Health identification card. Contact ASH Group to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described above and in the "Clinical Performance System" section of your Practitioner Operations Manual. CPT codes for Active Therapy (97110, 97140, 97530 and 97535) and Acupuncture (97810 and 97813) are also included under the Clinical Performance System for this Client.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Ultimate Health Plans
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/22
Revised 3/1/24

TYPE OF PLAN/EMPLOYER: Ultimate Health Plans is a health plan offering and/or administering health benefits in the following Florida counties: Citrus, Hernando, Hillsborough, Indian River, Lake, Manatee, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, and Sumter.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Members may be eligible for a subluxation benefit and/or supplemental benefit. Under the supplemental benefit covered conditions include musculoskeletal and related disorders and pain syndromes. The covered conditions are further defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH GROUP REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Group, ASH Group will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Group reimbursement is subject to coding rules adapted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule H11" attached. New/Established Patient Evaluation & Management is reimbursed separately from the Primary Service to provide a more extensive assessment than what is allowed within the work value associated with a Primary Service. (Contracted Practitioner may bill Primary Service separately.)
Primary Service: According to the "Services Fee Schedule H11" attached. A Primary Service is a spinal or extraspinal chiropractic manipulative treatment (CMT) or, in the absence of a CMT, an active therapy service. When an extraspinal CMT is billed with a spinal CMT it will be included in a maximum reimbursable amount for CMT. When an active therapy service is billed with a spinal CMT or extraspinal CMT the active therapy service is reimbursed at the Adjunctive Therapy fee levels. Spinal or extraspinal CMT represents all services related to the CMT including pre-service documentation, test interpretation and care planning, intra-service evaluation/palpation, manipulation and re-assessment, post-service chart documentation, consultation, and reporting.

Subluxation benefit: Member coverage is limited to a subluxation diagnosis and CPT codes 98940, 98941 and 98942.

Adjunctive Therapy: According to the "Services Fee Schedule H11" attached. When billed with an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $18 per date of service. When billed without an Evaluation & Management or Primary Service, Adjunctive Therapy will be reimbursed up to $24 per date of service.
Special Services: According to the "Services Fee Schedule H11" attached.
X-Rays: According to the "X-Ray Fee Schedule I4" attached or refer to an ASH Group ancillary radiology provider.
Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.
Laboratory Services: All Laboratory Services must be referred to an ASH Group ancillary laboratory provider.
Supports and Appliances: According to the "Supports and Appliances Fee Schedule R2" attached.
Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether an Adjustment is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Ultimate Health Plans identification card. Contact ASH Group to verify Member's Eligibility, Benefits, and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Group. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described above and in the "Clinical Performance System" section of your Practitioner Operations Manual. CPT codes for Active Therapy (97110, 97140 and 97530) are also included under the Clinical Performance System for this Client.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Group to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Group for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Group, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Group. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Group. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	D
99202	New patient evaluation & management service	$30.00
99203	New patient evaluation & management service	$32.00
99204	New patient evaluation & management service	$34.00
99205	New patient evaluation & management service	$36.00
99211	Established patient evaluation & management service	$18.00
99212	Established patient evaluation & management service	$20.00
99213	Established patient evaluation & management service	$22.00
99214	Established patient evaluation & management service	$24.00
99215	Established patient evaluation & management service	$26.00

CHIROPRACTIC MANIPULATIVE TREATMENT

CODE	DESCRIPTION	D
98940	Chiropractic manipulative treatment	$25.00
98941	Chiropractic manipulative treatment	$26.00
98942	Chiropractic manipulative treatment	$27.00
98943	Chiropractic manipulative treatment - extraspinal	$25.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	D
97010	Hot/cold packs	$10.00
97012	Traction, mechanical	$10.00
97014	Electrical stimulation (unattended)	$10.00
G0283	Electrical stimulation (unattended)	$10.00
97022	Whirlpool	$10.00
97024	Diathermy	$10.00
97032	Electrical stimulation (manual)	$10.00
97033	Iontophoresis	$10.00
97034	Contrast baths	$10.00
97035	Ultrasound	$10.00
97036	Hubbard tank	$10.00
97110	Therapeutic procedure, one or more areas; therapeutic exercises	$10.00
97112	Neuromuscular reeducation	$10.00
97113	Aquatic therapy with therapeutic exercises	$10.00
97116	Gait training (includes stair climbing)	$10.00
97124	Massage	$10.00
97140	Manual therapy techniques (i.e. manual traction, myofascial release)	$10.00
97530	Therapeutic activities, direct patient contact	$10.00
97535	Self-care/home management training	$10.00
97750	Physical performance test or measurement	$10.00
97760	Orthotic(s) management and training, each 15 min.	$10.00
97763	Orthotic(s)/prosthetic(s) management and/or training, subsequent encounter, each 15 minutes	$10.00

SPECIAL SERVICES

CODE	DESCRIPTION	D
29280	Strapping - any age - hand/finger	$10.00
29540	Strapping - any age - ankle/foot	$10.00
29550	Strapping - any age - toes	$10.00
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	U3
99202	New patient evaluation & management service	$59.67
99203	New patient evaluation & management service	$88.33
99204	New patient evaluation & management service	$125.65
99211	Established patient evaluation & management service	$20.00
99212	Established patient evaluation & management service	$34.95
99213	Established patient evaluation & management service	$48.96
99214	Established patient evaluation & management service	$76.32

CHIROPRACTIC MANIPULATIVE TREATMENT

CODE	DESCRIPTION	U3
98940	Chiropractic manipulative treatment	$24.38
98941	Chiropractic manipulative treatment	$33.36
98942	Chiropractic manipulative treatment	$43.71
98943	Chiropractic manipulative treatment - extraspinal	$26.20

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	U3
97012	Traction, mechanical	$13.77
97014	Electrical stimulation (unattended)	$13.59
G0283	Electrical stimulation (unattended)	$10.08
97022	Whirlpool	$14.36
97024	Diathermy	$10.08
97026	Infrared	$10.08
97032	Electrical stimulation (manual)	$14.89
97034	Contrast baths	$13.13
97035	Ultrasound	$11.28
97036	Hubbard tank	$21.86
97110	Therapeutic procedure, one or more areas; therapeutic exercises	$26.19
97112	Neuromuscular reeducation	$27.68
97113	Aquatic therapy with therapeutic exercises	$30.30
97116	Gait training (includes stair climbing)	$23.02
97124	Massage	$20.93
97140	Manual therapy techniques (i.e. manual traction, myofascial release)	$24.76
97530	Therapeutic activities, direct patient contact	$27.70
97535	Self-care/home management training	$28.42
97750	Physical performance test or measurement	$28.04
97760	Orthotic(s) management and training, each 15 min.	$10.08
97763	Orthotic(s)/prosthetic(s) management and/or training, subsequent each 15 minutes	$16.33

SPECIAL SERVICES

CODE	DESCRIPTION	U3
29260	Strapping - any age - elbow/wrist	$10.08
29280	Strapping - any age - hand/finger	$10.08
29520	Strapping - any age - hip	$10.08
29530	Strapping - any age - knee	$10.08
29540	Strapping - any age - ankle/foot	$10.08
29550	Strapping - any age - toes	$10.08

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

CHIROPRACTIC MANIPULATIVE TREATMENT

CODE	DESCRIPTION	D4
98940	Chiropractic manipulative treatment	$26.00
98941	Chiropractic manipulative treatment	$27.00
98942	Chiropractic manipulative treatment	$28.00

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	B6
99202	New patient evaluation & management service	$32.00
99203	New patient evaluation & management service	$34.00
99204	New patient evaluation & management service	$36.00
99211	Established patient evaluation & management service	$20.00
99212	Established patient evaluation & management service	$22.00
99213	Established patient evaluation & management service	$24.00
99214	Established patient evaluation & management service	$26.00

PRIMARY SERVICE

CODE	DESCRIPTION	B6
98940	Chiropractic manipulative treatment	$26.00
98941	Chiropractic manipulative treatment	$27.00
98942	Chiropractic manipulative treatment	$28.00
98943	Chiropractic manipulative treatment - extraspinal	$26.00
97110	Active therapy - active therapeutic exercise/therapeutic procedure	$22.00
97140	Active therapy - manual therapeutics	$22.00
97530	Active therapy - therapeutic activities, direct patient contact	$22.00
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 min. of personal one-on-one contact with patient.	$22.00
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 min. of personal one-on-one contact with patient.	$22.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	B6
97010	Hot/cold packs	$6.00
97012	Traction, mechanical	$6.00
97014	Electrical stimulation (unattended)	$6.00
G0283	Electrical stimulation (unattended)	$6.00
97022	Whirlpool	$12.00
97024	Diathermy	$6.00
97032	Electrical stimulation (manual)	$12.00
97033	Iontophoresis	$12.00
97034	Contrast baths	$12.00
97035	Ultrasound	$12.00
97036	Hubbard tank	$12.00
97110	Therapeutic procedure, one or more areas; therapeutic exercises	$18.00
97112	Neuromuscular reeducation	$18.00
97113	Aquatic therapy with therapeutic exercises	$18.00
97116	Gait training (includes stair climbing)	$18.00
97124	Massage	$18.00
97140	Manual therapy techniques (i.e. manual traction, myofascial release)	$18.00

ADJUNCTIVE THERAPY (Cont.)

CODE	DESCRIPTION	B6
97530	Therapeutic activities, direct patient contact	$18.00
97535	Self-care/home management training	$18.00
97760	Orthotic(s) management and training, each 15 min.	$18.00
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 min. of personal one-on-one contact with patient.	$18.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 min. of personal one-on-one contact with patient, with re-insertion of needle(s).	(20)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 min. of personal one-on-one contact with patient.	$18.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 min. of personal one-on-one contact with patient, with re-insertion of needle(s).	(20)

SPECIAL SERVICES

CODE	DESCRIPTION	B6
29280	Strapping - any age - hand/finger	$6.00
29540	Strapping - any age - ankle/foot	$6.00
29550	Strapping - any age - toes	$6.00

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

CHIROPRACTIC MANIPULATIVE TREATMENT

CODE	DESCRIPTION	G6
98940	Chiropractic manipulative treatment	$25.00
98941	Chiropractic manipulative treatment	$26.00
98942	Chiropractic manipulative treatment	$27.00

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

CHIROPRACTIC MANIPULATIVE TREATMENT

CODE	DESCRIPTION	Q6
98940	Chiropractic manipulative treatment	$23.00
98941	Chiropractic manipulative treatment	$28.00
98942	Chiropractic manipulative treatment	$29.00

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

EVALUATION & MANAGEMENT/CONSULTATION

CODE	DESCRIPTION	R6
97161	Physical therapy evaluation: low complexity	$32.00
97162	Physical therapy evaluation: moderate complexity	$32.00
97163	Physical therapy evaluation: high complexity	$32.00
97164	Re-evaluation of physical therapy established plan of care	$22.00
99202	New patient evaluation & management service	$32.00
99203	New patient evaluation & management service	$34.00
99204	New patient evaluation & management service	$36.00
99205	New patient evaluation & management service	$38.00
99211	Established patient evaluation & management service	$17.00
99212	Established patient evaluation & management service	$22.00
99213	Established patient evaluation & management service	$24.00
99214	Established patient evaluation & management service	$26.00
99215	Established patient evaluation & management service	$28.00
99241	Office consultation (problem focused)	$30.00
99242	Office consultation (expanded problem focused)	$32.00
99243	Office consultation (detailed)	$34.00
99244	Office consultation (comprehensive; moderately complex)	$36.00
99245	Office consultation (comprehensive; highly complex)	$38.00
99354	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	$12.00
99355	Each additional 30 minutes	$12.00

PRIMARY SERVICE

CODE	DESCRIPTION	R6
98940	Chiropractic manipulative treatment	$23.00
98941	Chiropractic manipulative treatment	$28.00
98942	Chiropractic manipulative treatment	$29.00
98943	Chiropractic manipulative treatment - extraspinal	$23.00
97110	Active therapy - active therapeutic exercise/therapeutic procedure	$22.00
97140	Active therapy - manual therapeutics	$22.00
97530	Active therapy - therapeutic activities, direct patient contact	$22.00
97535	Active therapy - self-care home management training	$22.00
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 min. of personal one-on-one contact with patient.	$22.00
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 min. of personal one-on-one contact with patient.	$22.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	R6
97010	Hot/cold packs	$6.00
97012	Traction, mechanical	$6.00
97014	Electrical stimulation (unattended)	$6.00
G0283	Electrical stimulation (unattended)	$6.00
97016	Vasopneumatic devices	$12.00
97018	Paraffin bath	$12.00
97022	Whirlpool	$12.00
97024	Diathermy	$6.00
97032	Electrical stimulation (manual)	$12.00
97033	Iontophoresis	$12.00
97034	Contrast baths	$12.00
97035	Ultrasound	$12.00
97036	Hubbard tank	$12.00
97039	Unlisted modality	$6.00
97110	Therapeutic procedure, one or more areas; therapeutic exercises	$18.00
97112	Neuromuscular reeducation	$18.00
97113	Aquatic therapy with therapeutic exercises	$18.00
97116	Gait training (includes stair climbing)	$18.00
97124	Massage	$18.00
97139	Unlisted therapeutic procedure	$6.00
97140	Manual therapy techniques (i.e. manual traction, myofascial release)	$18.00
97530	Therapeutic activities, direct patient contact	$18.00
97535	Self-care/home management training	$18.00
97750	Physical performance test or measurement	$18.00
97760	Orthotic(s) management and training, each 15 min.	$18.00
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 min. of personal one-on-one contact with patient.	$18.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 min. of personal one-on-one contact with patient, with re-insertion of needle(s).	(20)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 min. of personal one-on-one contact with patient.	$18.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 min. of personal one-on-one contact with patient, with re-insertion of needle(s).	(20)

SPECIAL SERVICES

CODE	DESCRIPTION	R6
29200	Strapping - any age - thorax	$6.00
29240	Strapping - any age - shoulder	$6.00
29260	Strapping - any age - elbow/wrist	$6.00
29280	Strapping - any age - hand/finger	$6.00
29520	Strapping - any age - hip	$6.00
29530	Strapping - any age - knee	$6.00
29540	Strapping - any age - ankle/foot	$6.00
29550	Strapping - any age - toes	$6.00
95851	Range of motion measurements and report; each extremity (excluding hand) or each trunk section	$18.00

LABORATORY SERVICES

CODE	DESCRIPTION	R6
81000	Urinalysis, by Dipstick non-Automated, with microscopy	$2.00
81002	Urinalysis, by Dipstick non-Automated, without Microscopy	$2.00

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	I7
99202	New patient evaluation & management service	$30.00
99203	New patient evaluation & management service	$32.00
99204	New patient evaluation & management service	$34.00
99205	New patient evaluation & management service	$36.00
99211	Established patient evaluation & management service	$18.00
99212	Established patient evaluation & management service	$20.00
99213	Established patient evaluation & management service	$22.00
99214	Established patient evaluation & management service	$24.00
99215	Established patient evaluation & management service	$26.00

PRIMARY SERVICE

CODE	DESCRIPTION	I7
97110	Active therapy - active therapeutic exercise/therapeutic procedure	$25.00
97112	Active therapy - Neuromuscular reeducation	$25.00
97116	Active therapy - Gait training (includes stair climbing)	$25.00
97530	Active therapy - therapeutic activities, direct patient contact	$25.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	I7
97110	Therapeutic procedure, one or more areas; therapeutic exercises	$10.00
97112	Neuromuscular reeducation	$10.00
97116	Gait training (includes stair climbing)	$10.00
97530	Therapeutic activities, direct patient contact	$10.00

SPECIAL SERVICES

CODE	DESCRIPTION	I7
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

If the services rendered are habilitative the CPT code must be submitted with a -96 or -SZ modifier.

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	G8
99202	New patient evaluation & management service	$30.00
99203	New patient evaluation & management service	$32.00
99204	New patient evaluation & management service	$34.00
99211	Established patient evaluation & management service	$18.00
99212	Established patient evaluation & management service	$20.00
99213	Established patient evaluation & management service	$22.00
99214	Established patient evaluation & management service	$24.00

PRIMARY SERVICE

CODE	DESCRIPTION	G8
98940	Chiropractic manipulative treatment	$26.00
98941	Chiropractic manipulative treatment	$27.00
98942	Chiropractic manipulative treatment	$28.00
98943	Chiropractic manipulative treatment - extraspinal	$26.00
97110	Active therapy - active therapeutic exercise/therapeutic procedure	$28.00
97140	Active therapy - manual therapeutics	$28.00
97530	Active therapy - therapeutic activities, direct patient contact	$28.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	G8
97012	Traction, mechanical	$6.00
97014	Electrical stimulation (unattended)	$6.00
G0283	Electrical stimulation (unattended)	$6.00
97022	Whirlpool	$12.00
97024	Diathermy	$6.00
97026	Infrared	$6.00
97032	Electrical stimulation (manual)	$12.00
97034	Contrast baths	$12.00
97035	Ultrasound	$12.00
97036	Hubbard tank	$12.00
97110	Therapeutic procedure, one or more areas; therapeutic exercises	$18.00
97112	Neuromuscular reeducation	$18.00
97113	Aquatic therapy with therapeutic exercises	$18.00
97116	Gait training (includes stair climbing)	$18.00
97124	Massage	$18.00
97140	Manual therapy techniques (i.e. manual traction, myofascial release)	$18.00
97530	Therapeutic activities, direct patient contact	$18.00
97535	Self-care/home management training	$18.00
97760	Orthotic(s) management and training, each 15 min.	$18.00

SPECIAL SERVICES

CODE	DESCRIPTION	G8
29280	Strapping - any age - hand/finger	$6.00
29540	Strapping - any age - ankle/foot	$6.00
29550	Strapping - any age - toes	$6.00

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	R10
99202(23)	New patient evaluation & management service	$32.00
99203(23)	New patient evaluation & management service	$34.00
99204	New patient evaluation & management service	$36.00
99205	New patient evaluation & management service	$38.00
99211(23)	Established patient evaluation & management service	$20.00
99212(23)	Established patient evaluation & management service	$22.00
99213(23)	Established patient evaluation & management service	$24.00
99214	Established patient evaluation & management service	$26.00
99215	Established patient evaluation & management service	$28.00
99421(23)	Qualified nonphysician health care professional online digital evaluation and management service	$10.00
99422(23)	Qualified nonphysician health care professional online digital evaluation and management service	$11.50
99423(23)	Qualified nonphysician health care professional online digital evaluation and management service	$13.00
99441(23)	Telephone assessment and management service	$10.00
99442(23)	Telephone assessment and management service	$11.50
99443(23)	Telephone assessment and management service	$13.00

PRIMARY SERVICE

CODE	DESCRIPTION	R10
98940	Chiropractic manipulative treatment	$26.00
98941	Chiropractic manipulative treatment	$27.00
98942	Chiropractic manipulative treatment	$28.00
98943	Chiropractic manipulative treatment - extraspinal	$26.00
97110	Active therapy - active therapeutic exercise/therapeutic procedure	$22.00
97140	Active therapy - manual therapeutics	$22.00
97530	Active therapy - therapeutic activities, direct patient contact	$22.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	R10
97010	Hot/cold packs	$6.00
97012	Traction, mechanical	$6.00
97014	Electrical stimulation (unattended)	$6.00
G0283	Electrical stimulation (unattended)	$6.00
97022	Whirlpool	$12.00
97024	Diathermy	$6.00
97026	Infrared	$6.00
97032	Electrical stimulation (manual)	$12.00
97033	Iontophoresis	$12.00
97034	Contrast baths	$12.00
97035	Ultrasound	$12.00
97036	Hubbard tank	$12.00
97110(23)	Therapeutic procedure, one or more areas; therapeutic exercises	$18.00
97112(23)	Neuromuscular reeducation	$18.00
97113	Aquatic therapy with therapeutic exercises	$18.00
97116	Gait training (includes stair climbing)	$18.00

ADJUNCTIVE THERAPY (Cont.)

CODE	DESCRIPTION	R10
97124	Massage	$18.00
97140	Manual therapy techniques (i.e. manual traction, myofascial release)	$18.00
97530[(23)]	Therapeutic activities, direct patient contact	$18.00
97535[(23)]	Self-care/home management training	$18.00
97750	Physical performance test or measurement	$18.00
97760	Orthotic(s) management and training, each 15 min	$18.00
97763	Orthotic(s)/prosthetic(s) management and/or training, subsequent encounter, each 15 minutes	$18.00

SPECIAL SERVICES

CODE	DESCRIPTION	R10
29280	Strapping - any age - hand/finger	$6.00
29540	Strapping - any age - ankle/foot	$6.00
29550	Strapping - any age - toes	$6.00
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	H11
99202	New patient evaluation & management service	$32.00
99203	New patient evaluation & management service	$34.00
99204	New patient evaluation & management service	$36.00
99205	New patient evaluation & management service	$38.00
99211	Established patient evaluation & management service	$20.00
99212	Established patient evaluation & management service	$22.00
99213	Established patient evaluation & management service	$24.00
99214	Established patient evaluation & management service	$26.00
99215	Established patient evaluation & management service	$28.00

PRIMARY SERVICE

CODE	DESCRIPTION	H11
98940-AT	Chiropractic manipulative treatment	$26.00
98941-AT	Chiropractic manipulative treatment	$27.00
98942-AT	Chiropractic manipulative treatment	$28.00
98943	Chiropractic manipulative treatment - extraspinal	$26.00
97110	Active therapy - active therapeutic exercise/therapeutic procedure	$22.00
97140	Active therapy - manual therapeutics	$22.00
97530	Active therapy - therapeutic activities, direct patient contact	$22.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	H11
97010	Hot/cold packs	$6.00
97012	Traction, mechanical	$6.00
97014	Electrical stimulation (unattended)	$6.00
G0283	Electrical stimulation (unattended)	$6.00
97022	Whirlpool	$12.00
97024	Diathermy	$6.00
97032	Electrical stimulation (manual)	$12.00
97033	Iontophoresis	$12.00
97034	Contrast baths	$12.00
97035	Ultrasound	$12.00
97036	Hubbard tank	$12.00
97110(23)	Therapeutic procedure, one or more areas; therapeutic exercises	$18.00
97112(23)	Neuromuscular reeducation	$18.00
97113	Aquatic therapy with therapeutic exercises	$18.00
97116	Gait training (includes stair climbing)	$18.00
97124	Massage	$18.00
97140	Manual therapy techniques (i.e. manual traction, myofascial release)	$18.00
97530(23)	Therapeutic activities, direct patient contact	$18.00
97535(23)	Self-care/home management training	$18.00
97750	Physical performance test or measurement	$18.00
97760	Orthotic(s) management and training, each 15 min	$18.00
97763	Orthotic(s)/prosthetic(s) management and/or training, subsequent encounter, each 15 minutes	$18.00

SPECIAL SERVICES

CODE	DESCRIPTION	H11
29280	Strapping - any age - hand/finger	$6.00
29540	Strapping - any age - ankle/foot	$6.00
29550	Strapping - any age - toes	$6.00
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

COMPREHENSIVE RADIOLOGY SERVICES:
Includes both of the technical and professional components of Radiology Services.

26/TC refers to Professional Component/Technical Component and the percentage of the ASH Group Radiological Fee Schedule that is payable for each of the two components, if approved by ASH Group.

CHEST

CODE	26/TC	DESCRIPTION	A
71045	40/60	Chest; single view	$23.00
71046	40/60	Chest; 2 views	$28.00
71047	40/60	Chest; 3 views	$34.00
71048	40/60	Chest; 4 or more views	$41.00
71100	40/60	Ribs, unilateral, 2 views	$44.00
71110	40/60	Ribs, bilateral, 3 views	$54.00
71120	40/60	Sternum, min. 2 views	$38.00

SPINE & PELVIS

CODE	26/TC	DESCRIPTION	A
72020	40/60	Single view spine, a/p lumbo	$23.00
72040	40/60	Spine, cervical; 3 views or less	$38.00
72050	40/60	Spine, cervical; 4 or 5 views	$60.00
72052	40/60	Spine, cervical, 6 or more views	$77.00
72070	40/60	Spine, thoracic, 2 views	$44.00
72080	40/60	Thoracolumbar, junction, minimum of 2 views	$44.00
72081	40/60	Spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg. Scoliosis evaluation); one view	$39.03
72082	40/60	Spine, entire thoracic and lumbar, 2 or 3 views	$62.66
72083	40/60	Spine, entire thoracic and lumbar, 4 or 5 views	$68.03
72084	40/60	Spine, entire thoracic and lumbar, minimum of 6 views	$81.28
72100	40/60	Spine, lumbosacral, 2 or 3 views	$44.00
72110	40/60	Lumbosacral complete, 4 view min.	$74.00
72170	40/60	Pelvis, 1 or 2 views	$31.00
72200	35/65	Sacroiliac joints - less than 3 views	$48.00
72220	35/65	Sacrum and coccyx, min. 2 views	$41.00

CHEST: UPPER EXTREMITIES

CODE	26/TC	DESCRIPTION	A
73000	35/65	Clavicle, complete	$31.00
73010	35/65	Scapula, complete	$38.00
73020	35/65	Shoulder, 1 view	$27.00
73030	35/65	Shoulder, complete; min. of 2 views	$38.00
73050	35/65	Acromioclavicular joints, bilateral, w/or w/out weighted distraction	$44.00
73060	35/65	Humerus, min. of 2 views	$31.00
73070	35/65	Elbow, 2 views	$28.00
73080	35/65	Elbow, complete min. 3 views	$38.00
73090	35/65	Forearm, 2 views	$38.00
73100	35/65	Wrist, 2 views	$38.00
73110	35/65	Wrist, complete, min. 3 views	$38.00
73120	40/60	Hand, 2 views	$27.00
73130	40/60	Hand, min. 3 views	$35.00
73140	40/60	Fingers(s), min. of 2 views	$23.00

LOWER EXTREMITIES

CODE	26/TC	DESCRIPTION	A
73501	40/60	Hip, unilateral, with pelvis when performed; 1 view	$29.72
73502	40/60	Hip, unilateral, 2-3 views	$41.53
73503	40/60	Hip, unilateral, minimum of 4 views	$51.92
73521	40/60	Hips, bilateral, with pelvis when performed, 2 views	$39.74
73522	40/60	Hips, bilateral, 3-4 views	$49.05
73523	40/60	Hips, bilateral, minimum of 5 views	$56.93
73551	40/60	Femur, 1 view	$27.93
73552	40/60	Femur, minimum of 2 views	$32.58
73560	40/60	Knee, 1 or 2 views	$35.00
73562	40/60	Knee, 3 views	$40.00
73564	40/60	Knee, complete, min. of 4 views	$47.00
73590	35/65	Tibia and fibula, 2 views	$31.00
73600	35/65	Ankle, 2 views	$27.00
73610	35/65	Ankle, complete, min. 3 views	$36.00
73620	35/65	Foot, 2 views	$25.00
73630	35/65	Foot, complete, min. 3 views	$34.00
73650	35/65	Calcaneus, min. 2 views	$27.00
73660	35/65	Toe(s), min. 2 views	$23.00

RADIOLOGICAL CONSULTATION

CODE	26/TC	DESCRIPTION	A
76140	N/A	Consultation on x-ray examination made elsewhere, written report	$28.00

COMPREHENSIVE RADIOLOGY SERVICES:
Includes both of the technical and professional components of Radiology Services.

26/TC refers to Professional Component/Technical Component and the percentage of the ASH Group Radiological Fee Schedule that is payable for each of the two components, if approved by ASH Group.

CHEST

CODE	26/TC	DESCRIPTION	P1
71045	40/60	Chest; single view	$23.00
71046	40/60	Chest; 2 views	$28.00
71047	40/60	Chest; 3 views	$34.00
71048	40/60	Chest; 4 or more views	$41.00
71100	40/60	Ribs, unilateral, 2 views	$44.00
71110	40/60	Ribs, bilateral, 3 views	$54.00
71120	40/60	Sternum, min. 2 views	$38.00

SPINE & PELVIS

CODE	26/TC	DESCRIPTION	P1
72020	40/60	Single view spine, a/p lumbo	$23.00
72040	40/60	Spine, cervical; 3 views or less	$38.00
72050	40/60	Spine, cervical; 4 or 5 views	$60.00
72052	40/60	Spine, cervical, 6 or more views	$77.00
72070	40/60	Spine, thoracic, 2 views	$44.00
72080	40/60	Thoracolumbar, junction, minimum of 2 views	$44.00
72081	40/60	Spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg. Scoliosis evaluation); one view	$39.03
72082	40/60	Spine, entire thoracic and lumbar, 2 or 3 views	$62.66
72083	40/60	Spine, entire thoracic and lumbar, 4 or 5 views	$68.03
72084	40/60	Spine, entire thoracic and lumbar, minimum of 6 views	$81.28
72100	40/60	Spine, lumbosacral, 2 or 3 views	$44.00
72110	40/60	Lumbosacral complete, 4 view min.	$74.00
72170	40/60	Pelvis, 1 or 2 views	$31.00
72200	35/65	Sacroiliac joints - less than 3 views	$48.00
72220	35/65	Sacrum and coccyx, min. 2 views	$41.00

CHEST: UPPER EXTREMITIES

CODE	26/TC	DESCRIPTION	P1
73000	35/65	Clavicle, complete	$31.00
73010	35/65	Scapula, complete	$38.00
73020	35/65	Shoulder, 1 view	$27.00
73030	35/65	Shoulder, complete; min. of 2 views	$38.00
73050	35/65	Acromioclavicular joints, bilateral, w/or w/out weighted distraction	$44.00
73060	35/65	Humerus, min. of 2 views	$31.00
73070	35/65	Elbow, 2 views	$28.00
73080	35/65	Elbow, complete min. 3 views	$38.00
73090	35/65	Forearm, 2 views	$38.00
73100	35/65	Wrist, 2 views	$38.00
73120	40/60	Hand, 2 views	$27.00
73130	40/60	Hand, min. 3 views	$35.00
73140	40/60	Fingers(s), min. of 2 views	$23.00

LOWER EXTREMITIES

CODE	26/TC	DESCRIPTION	P1
73501	40/60	Hip, unilateral, with pelvis when performed; 1 view	$29.72
73502	40/60	Hip, unilateral, 2-3 views	$41.53
73503	40/60	Hip, unilateral, minimum of 4 views	$51.92
73521	40/60	Hips, bilateral, with pelvis when performed, 2 views	$39.74
73522	40/60	Hips, bilateral, 3-4 views	$49.05
73523	40/60	Hips, bilateral, minimum of 5 views	$56.93
73551	40/60	Femur, 1 view	$27.93
73552	40/60	Femur, minimum of 2 views	$32.58
73560	40/60	Knee, 1 or 2 views	$35.00
73562	40/60	Knee, 3 views	$40.00
73564	40/60	Knee, complete, min. of 4 views	$47.00
73590	35/65	Tibia and fibula, 2 views	$31.00
73600	35/65	Ankle, 2 views	$27.00
73610	35/65	Ankle, complete, min. 3 views	$36.00
73620	35/65	Foot, 2 views	$25.00
73630	35/65	Foot, complete, min. 3 views	$34.00
73650	35/65	Calcaneus, min. 2 views	$27.00
73660	35/65	Toe(s), min. 2 views	$23.00

RADIOLOGICAL CONSULTATION

CODE	26/TC	DESCRIPTION	P1
76140	N/A	Consultation on x-ray examination made elsewhere, written report	$28.00

COMPREHENSIVE RADIOLOGY SERVICES:
Includes both of the technical and professional components of Radiology Services.

26/TC refers to Professional Component/Technical Component and the percentage of the ASH Group Radiological Fee Schedule that is payable for each of the two components, if approved by ASH Group.

CHEST

CODE	26/TC	DESCRIPTION	Z1
71045	40/60	Chest; single view	$25.39
71046	40/60	Chest; 2 views	$38.99
71047	40/60	Chest; 3 views	$44.43
71048	40/60	Chest; 4 or more views	$49.88
71100	40/60	Ribs, unilateral, 2 views	$44.43
71110	40/60	Ribs, bilateral, 3 views	$54.40
71120	40/60	Sternum, min. 2 views	$38.99

SPINE & PELVIS

CODE	26/TC	DESCRIPTION	Z1
72020	40/60	Single view spine, a/p lumbo	$23.57
72040	40/60	Spine, cervical; 3 views or less	$38.99
72050	40/60	Spine, cervical; 4 or 5 views	$60.75
72052	40/60	Spine, cervical, 6 or more views	$78.89
72070	40/60	Spine, thoracic, 2 views	$44.43
72080	40/60	Thoracolumbar, junction, minimum of 2 views	$44.43
72081	40/60	Spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg. Scoliosis evaluation); one view	$39.97
72082	40/60	Spine, entire thoracic and lumbar, 2 or 3 views	$64.16
72083	40/60	Spine, entire thoracic and lumbar, 4 or 5 views	$69.66
72084	40/60	Spine, entire thoracic and lumbar, minimum of 6 views	$83.23
72100	40/60	Spine, lumbosacral, 2 or 3 views	$44.43
72110	40/60	Lumbosacral complete, 4 view min.	$75.25
72114	40/60	Lumbosacral complete, including bending view	$95.20
72120	40/60	Spine, bending views only	$48.06
72170	40/60	Pelvis, 1 or 2 views	$31.73
72200	35/65	Sacroiliac joints - less than 3 views	$48.96
72202	35/65	Sacroiliac joints - min. 3 views	$51.68
72220	35/65	Sacrum and coccyx, min. 2 views	$41.71

CHEST: UPPER EXTREMITIES

CODE	26/TC	DESCRIPTION	Z1
73000	35/65	Clavicle, complete	$31.73
73010	35/65	Scapula, complete	$38.99
73020	35/65	Shoulder, 1 view	$27.21
73030	35/65	Shoulder, complete; min. of 2 views	$38.99
73050	35/65	Acromioclavicular joints, bilateral, w/or w/out weighted distraction	$44.43
73060	35/65	Humerus, min. of 2 views	$31.73
73070	35/65	Elbow, 2 views	$28.57
73080	35/65	Elbow, complete min. 3 views	$38.99
73090	35/65	Forearm, 2 views	$38.99
73100	35/65	Wrist, 2 views	$38.99
73120	40/60	Hand, 2 views	$27.21
73130	40/60	Hand, min. 3 views	$35.36
73140	40/60	Fingers(s), min. of 2 views	$23.57

LOWER EXTREMITIES

CODE	26/TC	DESCRIPTION	Z1
73501	40/60	Hip, unilateral, with pelvis when performed; 1 view	$30.43
73502	40/60	Hip, unilateral, 2-3 views	$42.53
73503	40/60	Hip, unilateral, minimum of 4 views	$53.17
73521	40/60	Hips, bilateral, with pelvis when performed, 2 views	$40.69
73522	40/60	Hips, bilateral, 3-4 views	$50.23
73523	40/60	Hips, bilateral, minimum of 5 views	$58.30
73551	40/60	Femur, 1 view	$28.60
73552	40/60	Femur, minimum of 2 views	$33.36
73560	40/60	Knee, 1 or 2 views	$36.02
73562	40/60	Knee, 3 views	$41.17
73564	40/60	Knee, complete, min. of 4 views	$40.80
73590	35/65	Tibia and fibula, 2 views	$31.73
73600	35/65	Ankle, 2 views	$27.21
73610	35/65	Ankle, complete, min. 3 views	$36.27
73620	35/65	Foot, 2 views	$25.39
73630	35/65	Foot, complete, min. 3 views	$34.45
73650	35/65	Calcaneus, min. 2 views	$27.21
73660	35/65	Toe(s), min. 2 views	$23.57

RADIOLOGICAL CONSULTATION

CODE	26/TC	DESCRIPTION	Z1
76140	N/A	Consultation on x-ray examination made elsewhere, written report	$28.57

COMPREHENSIVE RADIOLOGY SERVICES:
Includes both of the technical and professional components of Radiology Services.

26/TC refers to Professional Component/Technical Component and the percentage of the ASH Group Radiological Fee Schedule that is payable for each of the two components, if approved by ASH Group.

CHEST

CODE	26/TC	DESCRIPTION	M2
71045	40/60	Chest; single view	$23.00
71046	40/60	Chest; 2 views	$28.00
71047	40/60	Chest; 3 views	$34.00
71048	40/60	Chest; 4 or more views	$41.00
71100	40/60	Ribs, unilateral, 2 views	$44.00
71110	40/60	Ribs, bilateral, 3 views	$54.00
71120	40/60	Sternum, min. 2 views	$38.00

SPINE & PELVIS

CODE	26/TC	DESCRIPTION	M2
72020	40/60	Single view spine, a/p lumbo	$23.00
72040	40/60	Spine, cervical; 3 views or less	$38.00
72050	40/60	Spine, cervical; 4 or 5 views	$60.00
72052	40/60	Spine, cervical, 6 or more views	$77.00
72070	40/60	Spine, thoracic, 2 views	$44.00
72080	40/60	Thoracolumbar, junction, minimum of 2 views	$44.00
72081	40/60	Spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg. Scoliosis evaluation); one view	$39.03
72082	40/60	Spine, entire thoracic and lumbar, 2 or 3 views	$62.66
72083	40/60	Spine, entire thoracic and lumbar, 4 or 5 views	$68.03
72084	40/60	Spine, entire thoracic and lumbar, minimum of 6 views	$81.28
72100	40/60	Spine, lumbosacral, 2 or 3 views	$44.00
72110	40/60	Lumbosacral complete, 4 view min.	$74.00
72170	40/60	Pelvis, 1 or 2 views	$31.00
72200	35/65	Sacroiliac joints - less than 3 views	$48.00
72220	35/65	Sacrum and coccyx, min. 2 views	$41.00

CHEST: UPPER EXTREMITIES

CODE	26/TC	DESCRIPTION	M2
73000	35/65	Clavicle, complete	$31.00
73010	35/65	Scapula, complete	$38.00
73020	35/65	Shoulder, 1 view	$27.00
73030	35/65	Shoulder, complete; min. of 2 views	$38.00
73050	35/65	Acromioclavicular joints, bilateral, w/or w/out weighted distraction	$44.00
73060	35/65	Humerus, min. of 2 views	$31.00
73070	35/65	Elbow, 2 views	$28.00
73080	35/65	Elbow, complete min. 3 views	$38.00
73090	35/65	Forearm, 2 views	$38.00
73100	35/65	Wrist, 2 views	$38.00
73120	40/60	Hand, 2 views	$27.00
73130	40/60	Hand, min. 3 views	$35.00
73140	40/60	Fingers(s), min. of 2 views	$23.00

LOWER EXTREMITIES

CODE	26/TC	DESCRIPTION	M2
73501	40/60	Hip, unilateral, with pelvis when performed; 1 view	$29.72
73502	40/60	Hip, unilateral, 2-3 views	$41.53
73503	40/60	Hip, unilateral, minimum of 4 views	$51.92
73521	40/60	Hips, bilateral, with pelvis when performed, 2 views	$39.74
73522	40/60	Hips, bilateral, 3-4 views	$49.05
73523	40/60	Hips, bilateral, minimum of 5 views	$56.93
73551	40/60	Femur, 1 view	$27.93
73552	40/60	Femur, minimum of 2 views	$32.58
73560	40/60	Knee, 1 or 2 views	$35.00
73562	40/60	Knee, 3 views	$40.00
73564	40/60	Knee, complete, min. of 4 views	$47.00
73590	35/65	Tibia and fibula, 2 views	$31.00
73600	35/65	Ankle, 2 views	$27.00
73610	35/65	Ankle, complete, min. 3 views	$36.00
73620	35/65	Foot, 2 views	$25.00
73630	35/65	Foot, complete, min. 3 views	$34.00
73650	35/65	Calcaneus, min. 2 views	$27.00
73660	35/65	Toe(s), min. 2 views	$23.00

RADIOLOGICAL CONSULTATION

CODE	26/TC	DESCRIPTION	M2
76140	N/A	Consultation on x-ray examination made elsewhere, written report	$28.00

COMPREHENSIVE RADIOLOGY SERVICES:
Includes both of the technical and professional components of Radiology Services.

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CHEST

CODE	26/TC	DESCRIPTION	F3
71100	40/60	Ribs, unilateral, 2 views	$31.00
71110	40/60	Ribs, bilateral, 3 views	$34.00
71120	40/60	Sternum, min. 2 views	$38.00
71045	40/60	Chest; single view	$22.00
71046	40/60	Chest; 2 views	$27.00
71047	40/60	Chest; 3 views	$34.00
71048	40/60	Chest; 4 or more views	$41.00

SPINE & PELVIS

CODE	26/TC	DESCRIPTION	F3
72020	40/60	Single view spine, a/p lumbo	$20.00
72040	40/60	Spine, cervical; 3 views or less	$32.00
72050	40/60	Spine, cervical; 4 or 5 views	$44.00
72052	40/60	Spine, cervical, 6 or more views	$55.00
72070	40/60	Spine, thoracic, 2 views	$28.00
72072	40/60	Spine, Thoracic, 3 views	$32.39
72074	100/0	Spine, Thoracic, min. of 4 views	$38.75
72080	40/60	Thoracolumbar, junction, minimum of 2 views	$30.00
72081	40/60	Spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg. Scoliosis evaluation); one view	$39.03
72082	40/60	Spine, entire thoracic and lumbar, 2 or 3 views	$62.66
72083	40/60	Spine, entire thoracic and lumbar, 4 or 5 views	$68.03
72084	40/60	Spine, entire thoracic and lumbar, minimum of 6 views	$81.28
72100	40/60	Spine, lumbosacral, 2 or 3 views	$33.00
72110	40/60	Lumbosacral complete, 4 view min.	$46.00
72114	40/60	Lumbosacral complete, including bending view	$61.00
72120	40/60	Spine, bending views only	$42.00
72170	40/60	Pelvis, 1 or 2 views	$23.00
72190	40/60	Pelvis, complete, min. 3 views	$38.17
72200	35/65	Sacroiliac joints - less than 3 views	$25.00
72202	35/65	Sacroiliac joints - min. 3 views	$49.00
72220	35/65	Sacrum and coccyx, min. 2 views	$27.00

CHEST: UPPER EXTREMITIES

CODE	26/TC	DESCRIPTION	F3
73000	35/65	Clavicle, complete	$23.00
73010	35/65	Scapula, complete	$38.00
73020	35/65	Shoulder, 1 view	$20.00
73030	35/65	Shoulder, complete; min. of 2 views	$26.00
73050	35/65	Acromioclavicular joints, bilateral, w/or w/out weighted distraction	$44.00
73060	35/65	Humerus, min. of 2 views	$24.00
73070	35/65	Elbow, 2 views	$23.00
73080	35/65	Elbow, complete min. 3 views	$29.00
73090	35/65	Forearm, 2 views	$23.00
73100	35/65	Wrist, 2 views	$29.00
73110	35/65	Wrist, complete, min. 3 views	$33.26
73120	40/60	Hand, 2 views	$23.00
73130	40/60	Hand, min. 3 views	$26.00
73140	40/60	Fingers(s), min. of 2 views	$23.00

LOWER EXTREMITIES

CODE	26/TC	DESCRIPTION	F3
73501	40/60	Hip, unilateral, with pelvis when performed; 1 view	$29.72
73502	40/60	Hip, unilateral, 2-3 views	$41.53
73503	40/60	Hip, unilateral, minimum of 4 views	$51.92
73521	40/60	Hips, bilateral, with pelvis when performed, 2 views	$39.74
73522	40/60	Hips, bilateral, 3-4 views	$49.05
73523	40/60	Hips, bilateral, minimum of 5 views	$56.93
73551	40/60	Femur, 1 view	$27.93
73552	40/60	Femur, minimum of 2 views	$32.58
73560	40/60	Knee, 1 or 2 views	$25.00
73562	40/60	Knee, 3 views	$30.00
73564	40/60	Knee, complete, min. of 4 views	$34.00
73565	40/60	Knees (Both), standing, anteroposterior	$31.81
73590	35/65	Tibia and fibula, 2 views	$23.00
73600	35/65	Ankle, 2 views	$23.00
73610	35/65	Ankle, complete, min. 3 views	$27.00
73620	35/65	Foot, 2 views	$22.00
73630	35/65	Foot, complete, min. 3 views	$26.00
73650	35/65	Calcaneus, min. 2 views	$23.00
73660	35/65	Toe(s), min. 2 views	$23.00

OTHER IMAGING

CODE	26/TC	DESCRIPTION	F3
76140	N/A	Consultation on x-ray examination made elsewhere, written report	$14.00
76881	35/65	Ultrasound xtr non-vasc complete	$74.71
76882	35/65	Ultrasound xtr non-vasc lmtd	$21.23

COMPREHENSIVE RADIOLOGY SERVICES:
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26/TC refers to Professional Component/Technical Component and the percentage of the ASH Group Radiological Fee Schedule that is payable for each of the two components, if approved by ASH Group.

CHEST

CODE	26/TC	DESCRIPTION	I4
71045	40/60	Chest; single view	$23.00
71046	40/60	Chest; 2 views	$28.00
71047	40/60	Chest; 3 views	$34.00
71048	40/60	Chest; 4 or more views	$41.00
71100	40/60	Ribs, unilateral, 2 views	$30.00
71110	40/60	Ribs, bilateral, 3 views	$37.00
71120	40/60	Sternum, min. 2 views	$29.00

SPINE & PELVIS

CODE	26/TC	DESCRIPTION	I4
72020	40/60	Single view spine, a/p lumbo	$22.00
72040	40/60	Spine, cervical; 3 views or less	$33.00
72050	40/60	Spine, cervical; 4 or 5 views	$45.00
72052	40/60	Spine, cervical, 6 or more views	$56.00
72070	40/60	Spine, thoracic, 2 views	$31.00
72080	40/60	Thoracolumbar, junction, minimum of 2 views	$34.00
72081	40/60	Spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg. Scoliosis evaluation); one view	$39.00
72082	40/60	Spine, entire thoracic and lumbar, 2 or 3 views	$63.00
72083	40/60	Spine, entire thoracic and lumbar, 4 or 5 views	$68.00
72084	40/60	Spine, entire thoracic and lumbar, minimum of 6 views	$81.00
72100	40/60	Spine, lumbosacral, 2 or 3 views	$35.00
72110	40/60	Lumbosacral complete, 4 view min.	$49.00
72170	40/60	Pelvis, 1 or 2 views	$28.00
72200	35/65	Sacroiliac joints - less than 3 views	$28.00
72220	35/65	Sacrum and coccyx, min. 2 views	$28.00

CHEST: UPPER EXTREMITIES

CODE	26/TC	DESCRIPTION	I4
73000	35/65	Clavicle, complete	$28.00
73010	35/65	Scapula, complete	$30.00
73020	35/65	Shoulder, 1 view	$23.00
73030	35/65	Shoulder, complete; min. of 2 views	$29.00
73050	35/65	Acromioclavicular joints, bilateral, w/or w/out weighted distraction	$36.00
73060	35/65	Humerus, min. of 2 views	$27.00
73070	35/65	Elbow, 2 views	$28.00
73080	35/65	Elbow, complete min. 3 views	$31.00
73090	35/65	Forearm, 2 views	$26.00
73100	35/65	Wrist, 2 views	$29.00
73110	35/65	Wrist, complete, min. 3 views	$35.00
73120	40/60	Hand, 2 views	$26.00
73130	40/60	Hand, min. 3 views	$30.00
73140	40/60	Fingers(s), min. of 2 views	$31.00

LOWER EXTREMITIES

CODE	26/TC	DESCRIPTION	I4
73501	40/60	Hip, unilateral, with pelvis when performed; 1 view	$30.00
73502	40/60	Hip, unilateral, 2-3 views	$42.00
73503	40/60	Hip, unilateral, minimum of 4 views	$52.00
73521	40/60	Hips, bilateral, with pelvis when performed, 2 views	$40.00
73522	40/60	Hips, bilateral, 3-4 views	$49.00
73523	40/60	Hips, bilateral, minimum of 5 views	$57.00
73551	40/60	Femur, 1 view	$28.00
73552	40/60	Femur, minimum of 2 views	$33.00
73560	40/60	Knee, 1 or 2 views	$29.00
73562	40/60	Knee, 3 views	$34.00
73564	40/60	Knee, complete, min. of 4 views	$40.00
73590	35/65	Tibia and fibula, 2 views	$26.00
73600	35/65	Ankle, 2 views	$27.00
73610	35/65	Ankle, complete, min. 3 views	$31.00
73620	35/65	Foot, 2 views	$26.00
73630	35/65	Foot, complete, min. 3 views	$29.00
73650	35/65	Calcaneus, min. 2 views	$27.00
73660	35/65	Toe(s), min. 2 views	$28.00

RADIOLOGICAL CONSULTATION

CODE	26/TC	DESCRIPTION	I4
76140	N/A	Consultation on x-ray examination made elsewhere, written report	$28.00

SUPPORTS AND APPLIANCES

CODE	DESCRIPTION	A1
A4565	Sling	$10.00
A9300	Rehabilitation - gym ball/elastic tubing/band	$30.00
E0190	Positioning cushion/pillow/wedge	$30.00
L0120	Cervical collar - flexible foam	$15.00
L0625	Lumbar orthosis, flexible	$30.00
L0628	LSO, flexible	$30.00
L1820	Knee orthosis, elastic with condylar pads and joints	$35.00
L1906	Ankle foot orthosis	$18.00
L3030	Foot insert, removable, formed to patient's foot, each	$50.00
L3332	Heel lift	$2.00
L3334	Lift, elevation, heel, per inch	$2.00
L3678	Shoulder orthosis, prefabricated, off-the-shelf	$18.00
L3710	Elbow orthosis	$10.00
L3908	Wrist hand orthosis, wrist extension control cock-up	$18.00

Supports and Appliances not listed above are not covered.

SUPPORTS AND APPLIANCES

CODE	DESCRIPTION	J1
A4565	Sling	$10.60
A9300	Rehabilitation - gym ball/elastic tubing/band	$31.50
E0190	Positioning cushion/pillow/wedge	$31.50
E0860	Traction equipment, overdoor, cervical	$27.57
E0890	Home traction - lumbar	$37.12
L0120	Cervical collar - flexible foam	$15.91
L0625	Lumbar orthosis, flexible	$31.50
L0628	LSO, flexible	$31.50
L1820	Knee orthosis, elastic with condylar pads and joints	$37.12
L1906	Ankle foot orthosis	$19.09
L3030	Foot insert, removable, formed to patient's foot, each	$63.00
L3332	Heel lift	$2.12
L3702	Elbow orthosis, elastic with straps	$10.60
L3908	Wrist hand orthosis, wrist extension control cock-up	$19.09

Supports and Appliances not listed above are not covered.

SUPPORTS AND APPLIANCES

CODE	DESCRIPTION	G2
A4565	Sling	$10.00
A9300	Rehabilitation - gym ball/elastic tubing/band	$30.00
E0190	Positioning cushion/pillow/wedge	$30.00
L0120	Cervical collar - flexible foam	$15.00
L0625	Lumbar orthosis, flexible	$30.00
L0628	LSO, flexible	$30.00
L1820	Knee orthosis, elastic with condylar pads and joints	$35.00
L1906	Ankle foot orthosis	$18.00
L3030	Foot insert, removable, formed to patient's foot, each	$60.00
L3332	Heel lift	$5.00
L3334	Lift, elevation, heel, per inch	$5.00
L3678	Shoulder orthosis, prefabricated, off-the-shelf	$18.00
L3710	Elbow orthosis	$10.00
L3908	Wrist hand orthosis, wrist extension control cock-up	$18.00

Supports and Appliances not listed above are not covered.

SUPPORTS AND APPLIANCES

CODE	DESCRIPTION	R2
A4565	Sling	$10.00
A9300	Rehabilitation - gym ball/elastic tubing/band	$30.00
E0190	Positioning cushion/pillow/wedge	$30.00
L0120	Cervical collar - flexible foam	$15.00
L0625	Lumbar orthosis, flexible	$30.00
L0628	LSO, flexible	$30.00
L1820	Knee orthosis, elastic with condylar pads and joints	$35.00
L1906	Ankle foot orthosis	$18.00
L3030	Foot insert, removable, formed to patient's foot, each	$60.00
L3332	Heel lift	$5.00
L3334	Lift, elevation, heel, per inch	$5.00
L3678	Shoulder orthosis, prefabricated, off-the-shelf	$18.00
L3710	Elbow orthosis	$10.00
L3908	Wrist hand orthosis, wrist extension control cock-up	$18.00

Supports and Appliances not listed above are not covered.

SUPPORTS AND APPLIANCES

CODE	DESCRIPTION	W2
A4565	Sling	$10.00
A9300	Rehabilitation - gym ball/elastic tubing/band	$30.00
E0190	Positioning cushion/pillow/wedge	$30.00
L0120	Cervical collar - flexible foam	$15.00
L0625	Lumbar orthosis, flexible	$30.00
L0628	LSO, flexible	$30.00
L1820	Knee orthosis, elastic with condylar pads and joints	$35.00
L1906	Ankle foot orthosis	$18.00
L3030	Foot insert, removable, formed to patient's foot, each	$50.00
L3332	Heel lift	$2.00
L3334	Lift, elevation, heel, per inch	$2.00
L3678	Shoulder orthosis, prefabricated, off-the-shelf	$18.00
L3710	Elbow orthosis	$10.00
L3908	Wrist hand orthosis, wrist extension control cock-up	$18.00

Supports and Appliances not listed above are not covered.

SUPPORTS AND APPLIANCES

CODE	DESCRIPTION	O3
A4565	Sling	$10.00
E0190	Positioning cushion/pillow/wedge	$30.00
L0120	Cervical collar - flexible foam	$15.00
L0625	Lumbar orthosis, flexible	$30.00
L0628	LSO, flexible	$30.00
L1820	Knee orthosis, elastic with condylar pads and joints	$35.00
L1906	Ankle foot orthosis	$18.00
L3030	Foot insert, removable, formed to patient's foot, each	$50.00
L3332	Heel lift	$2.00
L3334	Lift, elevation, heel, per inch	$2.00
L3710	Elbow orthosis	$10.00
L3908	Wrist hand orthosis, wrist extension control cock-up	$18.00

Supports and Appliances not listed above are not covered.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	MAXIMUM FEE
99202	New patient evaluation & management service	$55.00
99203	New patient evaluation & management service	$75.00
99204	New patient evaluation & management service	$100.00
99205	New patient evaluation & management service	$140.00
99211	Established patient evaluation & management service	$25.00
99212	Established patient evaluation & management service	$35.00
99213	Established patient evaluation & management service	$45.00
99214	Established patient evaluation & management service	$65.00
99215	Established patient evaluation & management service	$95.00

CHIROPRACTIC MANIPULATIVE TREATMENT

CODE	DESCRIPTION	MAXIMUM FEE
98940	Chiropractic manipulative treatment	$40.00
98941	Chiropractic manipulative treatment	$45.00
98942	Chiropractic manipulative treatment	$55.00
98943	Chiropractic manipulative treatment - extraspinal	$35.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	MAXIMUM FEE
97010	Hot/cold packs	$18.00
97012	Traction, mechanical	$18.00
97014	Electrical stimulation (unattended)	$18.00
G0283	Electrical stimulation (unattended)	$18.00
97022	Whirlpool	$18.00
97024	Diathermy	$18.00
97032	Electrical stimulation (manual)	$18.00
97033	Iontophoresis	$18.00
97034	Contrast baths	$18.00
97035	Ultrasound	$18.00
97036	Hubbard tank	$18.00
97110	Therapeutic procedure, one or more areas; therapeutic exercises	$18.00
97112	Neuromuscular reeducation	$18.00
97113	Aquatic therapy with therapeutic exercises	$18.00
97116	Gait training (includes stair climbing)	$18.00
97124	Massage	$18.00
97140	Manual therapy techniques (i.e. manual traction, myofascial release)	$18.00
97530	Therapeutic activities, direct patient contact	$18.00
97535	Self-care/home management training	$18.00

ADJUNCTIVE THERAPY (Cont.)

CODE	DESCRIPTION	MAXIMUM FEE
97750	Physical performance test or measurement	$18.00
97760	Orthotic(s) management and training, each 15 min.	$18.00
97763	Orthotic(s)/prosthetic(s) management and/or training, subsequent encounter, each 15 minutes	$18.00

SPECIAL SERVICES

CODE	DESCRIPTION	MAXIMUM FEE
29280	Strapping - any age - hand/finger	$18.00
29540	Strapping - any age - ankle/foot	$18.00
29550	Strapping - any age - toes	$18.00
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$18.00

The Maximum Fee Schedule for other CPT Codes and/or services for treatment, examination and/or therapy would be the State Workers' Compensation Fee Schedule.

COMPREHENSIVE RADIOLOGY SERVICES:
Includes both of the technical and professional components of Radiology Services.

26/TC refers to Professional Component/Technical Component and the percentage of the ASH Group Radiological Fee Schedule that is payable for each of the two components, if approved by ASH Group.

CHEST

CODE	26/TC	DESCRIPTION	MAXIMUM FEE
71045	40/60	Chest; single view	$31.25
71046	40/60	Chest; 2 views	$47.50
71047	40/60	Chest; 3 views	$55.00
71048	40/60	Chest; 4 or more views	$61.25
71100	40/60	Ribs, unilateral, 2 views	$55.00
71110	40/60	Ribs, bilateral, 3 views	$67.50
71120	40/60	Sternum, min. 2 views	$47.50

SPINE & PELVIS

CODE	26/TC	DESCRIPTION	MAXIMUM FEE
72020	40/60	Single view spine, a/p lumbo	$29.00
72040	40/60	Spine, cervical; 3 views or less	$47.50
72050	40/60	Spine, cervical; 4 or 5 views	$75.00
72052	40/60	Spine, cervical, 6 or more views	$96.25
72070	40/60	Spine, thoracic, 2 views	$55.00
72080	40/60	Thoracolumbar, junction, minimum of 2 views	$55.00
72081	40/60	Spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg. Scoliosis evaluation); one view	$39.03
72082	40/60	Spine, entire thoracic and lumbar, 2 or 3 views	$62.66
72083	40/60	Spine, entire thoracic and lumbar, 4 or 5 views	$68.03
72084	40/60	Spine, entire thoracic and lumbar, minimum of 6 views	$81.28
72100	40/60	Spine, lumbosacral, 2 or 3 views	$55.00
72110	40/60	Lumbosacral complete, 4 view min.	$92.50
72170	40/60	Pelvis, 1 or 2 views	$38.75
72200	35/65	Sacroiliac joints - less than 3 views	$60.00
72220	35/65	Sacrum and coccyx, min. 2 views	$51.25

CHEST: UPPER EXTREMITIES

CODE	26/TC	DESCRIPTION	MAXIMUM FEE
73000	35/65	Clavicle, complete	$38.75
73010	35/65	Scapula, complete	$47.50
73020	35/65	Shoulder, 1 view	$33.75
73030	35/65	Shoulder, complete; min. of 2 views	$47.50
73050	35/65	Acromioclavicular joints, bilateral, w/or w/out weighted distraction	$55.00
73060	35/65	Humerus, min. of 2 views	$38.75
73070	35/65	Elbow, 2 views	$35.00
73080	35/65	Elbow, complete min. 3 views	$47.50
73090	35/65	Forearm, 2 views	$47.50
73100	35/65	Wrist, 2 views	$47.50
73110	35/65	Wrist, complete, min. 3 views	$47.50
73120	40/60	Hand, 2 views	$33.75
73130	40/60	Hand, min. 3 views	$43.75
73140	40/60	Fingers(s), min. of 2 views	$28.75

LOWER EXTREMITIES

CODE	26/TC	DESCRIPTION	MAXIMUM FEE
73501	40/60	Hip, unilateral, with pelvis when performed; 1 view	$29.72
73502	40/60	Hip, unilateral, 2-3 views	$41.53
73503	40/60	Hip, unilateral, minimum of 4 views	$51.92
73521	40/60	Hips, bilateral, with pelvis when performed, 2 views	$39.74
73522	40/60	Hips, bilateral, 3-4 views	$49.05
73523	40/60	Hips, bilateral, minimum of 5 views	$56.93
73551	40/60	Femur, 1 view	$27.93
73552	40/60	Femur, minimum of 2 views	$32.58
73560	40/60	Knee, 1 or 2 views	$43.75
73562	40/60	Knee, 3 views	$50.00
73564	40/60	Knee, complete, min. of 4 views	$58.75
73590	35/65	Tibia and fibula, 2 views	$38.75
73600	35/65	Ankle, 2 views	$33.75
73610	35/65	Ankle, complete, min. 3 views	$45.00
73620	35/65	Foot, 2 views	$31.25
73630	35/65	Foot, complete, min. 3 views	$42.50
73650	35/65	Calcaneus, min. 2 views	$33.75
73660	35/65	Toe(s), min. 2 views	$28.75

RADIOLOGICAL CONSULTATION

CODE	26/TC	DESCRIPTION	MAXIMUM FEE
76140	N/A	Consultation on x-ray examination made elsewhere, written report	$35.00

SUPPORTS AND APPLIANCES

CODE	DESCRIPTION	MAXIMUM FEE
A4565	Sling	$10.00
A9300	Rehabilitation - gym ball/elastic tubing/band	$60.00
E0190	Positioning cushion/pillow/wedge	$60.00
L0120	Cervical collar - flexible foam	$10.00
L0625	Lumbar orthosis, flexible	$60.00
L0628	LSO, flexible	$60.00
L1820	Knee orthosis, elastic with condylar pads and joints	$45.00
L1906	Ankle foot orthosis	$36.00
L3030	Foot insert, removable, formed to patient's foot, each	$60.00
L3332	Heel lift	$4.00
L3334	Lift, elevation, heel, per inch	$4.00
L3678	Shoulder orthosis, prefabricated, off-the-shelf	$18.00
L3710	Elbow orthosis	$20.00
L3908	Wrist hand orthosis, wrist extension control cock-up	$36.00

Supports and Appliances not listed above are not covered.

Fee Schedule Footnotes

(20) Reimbursed under the all-inclusive, maximum reimbursable amount for Acupuncture (CPT codes 97810 and 97813).

(23) CPT code is eligible as a telehealth service for eligible health plan clients.