

# **“The Healthy Bundle”**

Chiropractic / Acupuncture, Dental & Vision Ancillary Benefits

*Rounding Out Your Benefits Package is as easy as 1, 2, 3.*

## **1) Chiropractic / Acupuncture Benefits\***

\*Please include a copy of your current Medical Insurance ID Card

Office Visit	\$20 co-payment
Maximum Annual Visits	30 visits per year
X-ray Services	\$75 annual max. (Dr's UCR - \$75 Allowance)
Emergency Chiropractic Care	Same co-payment as office visit

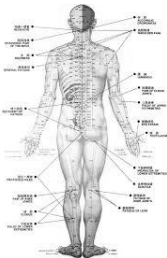
## **2) Comprehensive Liberty Dental** (Sample Benefits\*)

<u>ADA Code</u>	<u>Procedure</u>	<u>Co Payment</u>
D0120	Examination	\$0
D0210	X Rays	\$0
D1110	Cleanings	\$0
D2140	Fillings	\$0*
D2710 thru D2794	Crowns	\$70~
D3330	Root Canal (excluding final restoration)	\$105
D4210	Deep Cleaning	\$40 / Quadrant
D5110	Complete Denture (upper or lower)	\$85
Pair & a Spare Vision	Unlimited Access Various Co Pays	Included

\*This is only a partial list of covered benefits. Please see the Benefits Schedules for a complete listing of all Dental and Vision Co Payments.

## **3) Comprehensive VPA Vision**

Annual Co Payment	\$25 - Each 12 Months
Complete Eye Exam	Each 12 Months
Standard Lenses (SV, BF, TF)	Each 12 Months
Frames	\$100 allowance - Each 12 Months
Contact Lenses	\$100 allowance - Each 12 Months (in lieu of frames & lenses)
Quasight LASIK	Included



### Chiropractic / Acupuncture Definitions

**1. Chiropractic Treatment** - Covered Chiropractic Services are those within the scope of chiropractic care that are supportive or necessary to help Members achieve the physical state enjoyed before an injury or illness. In addition, services for preventive, maintenance, and wellness care for any mechanical neuromusculoskeletal condition are also covered. Services need not be pre-authorized, will not be reviewed for Medical Necessity, and include the following: **Examinations, Manipulations, Conjointive Physiotherapy, X-rays, Emergency Services**

**2. Acupuncture Treatment** - Covered Acupuncture Services are those within the scope of acupuncture care for the treatment of neuromusculoskeletal pain resulting from an injury or illness. In addition, coverage is provided for preventive, maintenance and wellness care for any mechanical neuromusculoskeletal condition, uncomplicated asthma (that which is not effected by another condition or disease), allergies, post-operative or chemo-therapy nausea and vomiting, nausea of pregnancy, post-operative (including dental) pain, fibromyalgia, headaches and low-back pain. Services need not be pre-authorized, will not be reviewed for Medical Necessity, and include the following: **Acupuncture, Electro-acupuncture, Moxibustion, Cupping, Acupressure**

**3. Emergency Services** - Emergency Services are covered for the sudden and unexpected onset of an acute illness, extreme neuromusculoskeletal pain or accidental injury to the nervous, musculoskeletal and/or skeletal body systems, that, in the reasonable judgment of the Member, re-quires immediate care, the delay of which could de-crease the likelihood of maximum recovery, and for which the Member seeks to secure chiropractic or acupuncture services immediately after the onset, or as soon thereafter as practicable. Emergency Services do not require pre-authorization; however, Emergency Services rendered by a Non-Participating Practitioner are subject to Carrier's determination that the Member would reasonably have considered that Emergency Services were required. Emergency Services rendered by a Non-Participating Practitioner are covered only when the practitioner rendering services can show that the services were for a neuromusculoskeletal condition and/or illness and were provided to reduce the severity of the condition including pain until a Participating Practitioner could safely assume treatment. Similarly, Emergency Services received outside of Carrier's Service Area will be covered only when the Non-Participating Practitioner rendering services can show that the services were for a neuromusculoskeletal condition and/or illness and were provided to reduce the severity of the condition including pain until a Participating Practitioner could safely assume treatment. Under the Carrier Plan, emergency care must be transferred to a Participating Practitioner as soon as such transfer would not create an unreasonable risk to the Member's health.

### Circumstances Causing Services to be Excluded or Limited

1. Services provided by a Non-Participating Practitioner, except for emergencies - 2. Services provided outside of Carrier's Service Area, except for emergencies - 3. Services incurred prior to the beginning or after the end of coverage - 4. Services that exceed the combined maximum covered visits for the benefit year - 5. Charges incurred for missed appointments - 6. Educational programs - 7. Pre-employment, school entrance, or athletic physical exams - 8. Services for conditions arising out of employment, including self-employment or covered under any workers' compensation act or law - 9. Services for any bodily injury arising from or sustained in an automobile accident that is covered under an automobile insurance policy - 10. Charges for which the Member is not legally required to pay - 11. Services rendered by a person who ordinarily resides in the Member's home or who is related to the Member by marriage or blood.

### Specific Services that are Excluded or Limited

1. Drugs, vitamins, nutritional supplements, or herbs - 2. Experimental or investigational services - 3. Vocational, stroke, or long-term rehabilitation - 4. Hypnotherapy, behavior training, sleep therapy, or biofeedback - 5. Rental or purchase of -durable Medical Equipment (DME) - 6. Treatment primarily for purposes of weight control - 7. Lab services - 8. Thermography, hair analysis, heavy metal screening, or mineral studies - 9. Transportation costs, including ambulance charges - 10. Inpatient services - 11. Advanced diagnostic services, such as MRI, CT, EMG, SEMG, and NCV.

### Chiropractic Only Limitations/Exclusions

1. Massage or soft-tissue techniques - 2. Manipulation under anesthesia - 3. Services related to diagnosis and treatment of jaw joint or TMJ disorders - 4. Treatment of non-neuromusculoskeletal disorders - 5. X-ray services that exceed the \$75 annual maximum benefit

### Acupuncture Only Limitations/Exclusions

1. Massage or soft-tissue techniques other than acupressure as defined in your Evidence of Coverage - 2. X-rays of any kind - 3. Services related to menstrual cramps - 4. Services related to addiction, including smoking cessation - 6. Treatment of non-neuromusculoskeletal disorders except for those described under "Acupuncture Treatment" above.

### Dental Only Limitations & Exclusions

\* Not all procedures in this category are listed, please see the complete benefit schedule for details

~ *GUIDELINES for Pontics and Abutment Inlays, Onlays and Crowns*

The total maximum amount chargeable to the member for elective upgraded procedures (explained below) is \$250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure. 1. Brand name restorations (e.g. Sunrise, Captek, Vitadur-N, Hi-Ceram, Optec, HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.) may be considered elective upgraded procedures if their related CDT procedure codes are not listed as covered benefits. 2. Benefits for anterior and bicuspid teeth: Resin, porcelain and any resin to base metal or porcelain to base metal crowns are covered benefits for anterior and bicuspid teeth. Adding a porcelain margin may be considered an elective upgraded procedure. 3. Benefits for molar teeth: Cast base metal restorations are covered benefits for molar teeth. Resin-based composite and porcelain/ceramic crowns are not covered benefits on molar teeth. Any resin to metal or porcelain to metal crowns may be considered elective upgraded procedures. Adding a porcelain margin may be considered an elective upgraded procedure. 4. Base metal is the benefit. If elected, the member may be charged additional lab costs for a) noble metal, b) high noble metal, or c) *titanium*.

### Vision Only Limitations and Exclusions

1. Services which are provided without cost to the Member by any municipality, county or other subdivision.  
2. Service to which the Member is entitled under any Worker's Compensation Law or Act. This exclusion does not apply to the MediCal Program.  
3. Medical or surgical treatment of the eyes (Dilation, tests related to dilation and extended exams) including specialized visual fields.  
4. Services that cannot be performed in the Participating Providers office for any reason including the general health of the patient.



The Camden Insurance Agency

An affiliate of Vision Plan of America

### Credit Card / ACH Authorization & Enrollment Form

Name (Last, First): \_\_\_\_\_ Language Preference: \_\_\_\_\_

Address: \_\_\_\_\_ Apt.# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email Address: \_\_\_\_\_

Social Sec. Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Vision Provider Office Code Selected  # \_\_\_\_\_ Dental Provider Office Code Selected  # \_\_\_\_\_

If no office is selected, we will choose an office near your home Zip Code. You may update your provider selection at any time.

#### Monthly Coverage Rates\* (please check all that apply):

	Chiro / Acu. ONLY	Comp. Dental ONLY	Comp. Vision ONLY	Dental & Vision & Chiro / Acu.	Create Your Own Combo
Single	<input type="checkbox"/> \$16.00	<input type="checkbox"/> \$29.00	<input type="checkbox"/> \$12.00	<input type="checkbox"/> \$57.00	<input type="checkbox"/> \$
+ 1 (Spouse or Child)	<input type="checkbox"/> \$31.00	<input type="checkbox"/> \$46.00	<input type="checkbox"/> \$22.00	<input type="checkbox"/> \$99.00	<input type="checkbox"/> \$
+ Family	<input type="checkbox"/> \$46.00	<input type="checkbox"/> \$64.00	<input type="checkbox"/> \$33.00	<input type="checkbox"/> \$143.00	<input type="checkbox"/> \$

\* A \$10 one time, non-refundable enrollment fee will be added to your first month's premium.

#### Addition Levels of Coverage are available upon request

#### For Monthly Credit Card Transactions:

Credit Card Type (please check one):  Visa  MasterCard  Discover  American Express

Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration Date: \_\_\_\_\_

#### For Monthly Automatic Checking Account Draft:

**Please Attach a Check with Your First Payment. Subsequent payments will be deducted from your account.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I wish to enroll in the "Healthy Bundle" Program. THIS CONTRACT IS FOR A MINIMUM OF 12 MONTHS from the effective date and renews at 12 month increments. I understand that all necessary services will be provided as described in the Evidence of Coverage to be provided upon enrollment. I hereby authorize the Camden Insurance Agency, or its designate, to charge my Credit Card / Checking Account the applicable monthly premium to be credited to my account. This authority is to remain in full force and effect until I notify The Camden Insurance Agency in writing of my desire to terminate coverage, thirty days thereafter my benefits will end. If the benefits are utilized, the contract will remain in effect through the contract period. Enrollment in this program automatically enrolls you in the CMA Association, for which there are no monthly fees.