



MediClassic[®]

COVERED SERVICES
CHOICE PLAN

COVERED SERVICES

This section sets forth eligible Health Care Services. Except for preventative care services, all such services must be deemed to be Medically Necessary by the Member's Primary Care Physician and such services are subject to the Limitations, Exclusions and Conditions Section.

A. Annual Physical Examination: A general physical examination per Contract Year that shall include: a medical, family and social history, and Lab tests if deemed Medically Necessary by the Member's Primary Care Physician. Any Lab tests and/or Diagnostic and Therapeutic Services are subject to the Co-payment.

**\$5 COPAYMENT PER EXAMINATION IF PERFORMED BY PCP
\$40 COPAYMENT IF PERFORMED BY GYNECOLOGIST**

B. Adult Primary Care Physician (PCP) Office Visit: The following are considered Covered Services if provided by the Member's Primary Care Physician: Any Lab tests and/or Diagnostic and Therapeutic Services are subject to the additional Co-payment.

- Office Consultations and referrals. Initial and follow up visits.
- Office visits for Medical Conditions as scheduled and directed by the Member's Primary Care Physician.
- Authorizations for Covered Services deemed Medically Necessary by the Member's Primary Care Physician.

\$5 COPAYMENT PER OFFICE VISIT

C. Pediatrics: Well Child Preventive Health Care Services: From age 2 (two) through age 17, services include a physical examination, developmental assessment and anticipatory guidance, consultation and treatment. Any Lab tests and/or Diagnostic and Therapeutic Services are subject to the additional Co-payment.

\$25 COPAYMENT PER OFFICE VISIT

D. Adult Specialist Physician's Office Visit. Plan Physicians include the following specialties: Cardiology, Dermatology, ENT Otolaryngology (ear, nose and throat), Endocrinology, Nephrology, Gastrointestinal, General Surgeon, Neurology, Oncology, Ophthalmology, Optometry, Orthopedics, Pulmonology, Rheumatologist, and Urology when referred by the Member's Primary Care Physician and Covered Services are authorized by The Member's PCP. Covered Services include office visits and consultations. Any Lab tests and/or Diagnostic and Therapeutic Services are subject to the additional Co-payment.

\$40 COPAYMENT PER OFFICE VISIT

E. Gynecologist. A female Member is allowed to visit a Participating gynecologist for one annual exam without authorization or referral from the Member's Primary Care Physician, or when referred by the Member's Primary Care Physician and Covered Services are authorized by The Member's PCP. Any Medically Necessary follow-up care detected at those visits must be coordinated with the Member's Primary Care Physician. Any Lab tests and/or Diagnostic and Therapeutic Services are subject to the additional Co-payment.

\$40 COPAYMENT PER OFFICE VISIT



F. Minor Office Surgery. performed in the Member’s Primary Care Physician’s office or a Specialist Physician’s office upon referral by the Member’s PCP. Any Lab tests and/or Diagnostic and Therapeutic Services are subject to the additional Co-payment. Covered Services are limited to the following:

- a. Malignant Lesion
 - Excision 0. 5 cm or less
- b. Pilonidal cyst
 - Excision
- c. Dermal Lesion
 - Cauterization
 - Excision 0.5 cm or less
- d. Excision of skin lump
 - Cauteriazation
 - Excision 0.5 cm or less
- e. Fine needle aspiration
 - Thyroid nodule
- f. Application of Cast

\$150 COPAYMENT PER VISIT

G. Clinic Priority Care. Priority Care Centers provide Covered Services that the Member may require immediately rather than wait for an appointment with his or her Primary Care Physician, or services that may be required after physician office hours. Clinic Priority Care does not render urgent or emergency care services. Any Lab tests and/or Diagnostic and Therapeutic Services are subject to the additional Co-payment.

\$150 COPAYMENT PER VISIT

H. Laboratory Services: Diagnostic laboratory services performed in the Member’s Primary Care Physician’s office or with a written referral to a Plan Specialist or outpatient facility.

ROUTINE TEST: \$10 COPAYMENT PER TEST (Attachment B)
NON-ROUTINE TEST: See Attachment B for COPAYMENT PER TEST

I. Diagnostic and Therapeutic Services: The following Covered Services performed in the Member’s Primary Care Physician’s office or with a written referral to a Plan Specialist or Plan outpatient diagnostic facility are covered.

Test	Copayment
24 Hour Holter Monitor	\$ 60.00
Audiometry	\$ 25.00
Bone Densitometry	\$ 80.00
Cardiac Stress Test (plain)	\$ 250.00
CT Scan with contrast	\$ 110.00
CT Scan without contrast	\$ 180.00
Diagnostic Ultrasound	\$ 40.00
Echocardiogram Doppler	\$ 125.00



Electrocardiogram	\$ 15.00
Electroencephalogram	\$ 100.00
Endoscopies/Colonoscopies	\$ 200.00
Mammogram	\$ 50.00
MRI (Magnetic Resources Imaging) Combined	\$ 400.00
MRI (Magnetic Resources Imaging) with Contrast	\$ 350.00
MRI (Magnetic Resources Imaging) without Contrast	\$ 300.00
Nerve Conduction Velocity Studies per Area	\$ 80.00
Nuclear Medicine	\$ 400.00
Vascular Ultrasonography	\$ 100.00
X-ray Contrast	\$ 100.00
X-ray Plain	\$ 25.00
Vaginal Ultrasound	\$ 80.00

J. Outpatient Physical Therapy Services. Physical therapy ordered by the Member's Primary Care Physician as Medically Necessary for the purpose of aiding in the restoration of normal bodily function is covered on an outpatient basis only and must be performed by a Plan Provider referred by the Member's PCP. Any Lab tests and/or Diagnostic and Therapeutic Services are subject to the additional Co-payment.

\$30 COPAYMENT PER VISIT

K. Second Medical Opinion. As a SFPHC Member, You are entitled to a second medical opinion under the following conditions:

Whenever a minor surgical procedure is recommended to confirm the need for the procedure; Whenever a serious injury or illness exists; or Whenever You find that You are not responding to the current treatment plan in a satisfactory manner.

If requested, the second opinion consultation is to be provided by a Physician of the Member's choice. The Member may select a Plan Physician listed in the SFPHC Provider Directory or a Non-Plan Physician located in the SFPHC Service Area. If a Member chooses a Plan Physician, he or she will only be responsible for the applicable Co-payment. If a Member chooses a Non-Plan Physician, SFPHC will pay 60% of the usual and customary charge for the second opinion. At the time of service, the Member must pay the Non-Plan Physician the entire charge incurred for the second opinion and submit a claim to SFPHC. SFPHC will reimburse the Member the usual and customary amount for the second opinion consultation less 40% of such amount.

If a Member would like a second medical opinion, the Member must first notify his or her Primary Care Physician who will initiate a request for consultation. Any Covered diagnostic tests requested by the Physician providing the second opinion must be coordinated by the Member's Primary Care Physician, and if Medically Necessary, performed by a SFPHC Plan Physician.

The Physician providing the second opinion will provide the Member's Primary Care Physician with a written opinion. Please note that the Physician who provides the second opinion will not perform the surgery or initiate any treatment to correct the condition for which the original recommendation was given, unless authorized by the Member's Primary Care Physician.

Any Lab tests and/or Diagnostic and Therapeutic Services are subject to the additional Co-payment.



LIMITATIONS, EXCLUSIONS AND CONDITIONS

Exclusions

All Covered Services must be provided by or arranged for by the Member's Primary Care Physician. Covered Services that are not provided by or arranged for by the Member's PCP are excluded. Additionally, all services and benefits set forth below are specifically excluded from coverage under this Contract except if otherwise expressly provided for in the Covered Services Section.

1. Acupuncture services.
2. All costs associated with the delivery of a newborn child.
3. Anesthesia
4. Any Covered care or treatment provided by Non-Plan physicians, health professionals or outpatient facilities.
5. Any Covered treatment, procedure, service or supply which is not determined by the Member's Primary Care Physician or SFPHC to be Medically Necessary to prevent, diagnose, or treat a Condition, illness, injury or bodily malfunction.
6. Any prescription or regimen, Medical or surgical or non-surgical procedure or treatment, for the purpose of reducing or controlling weight.
7. Any service or supply in connection with a transplant, implant; any service or supply in connection with identification of an organ donor from a local, state, or national listing, or any service provided to an organ donor or prospective donor.
8. Any services related to autologous blood collection and storage, and synthetic blood products.
9. Any treatments, procedures, services or supplies other than those specified in the Covered Services Section.
10. Arch supports, orthopedic shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use.
11. Biofeedback, sleep disorder studies and/or equipment, self-help training and educational programs, including programs primarily for pain management or vocational rehabilitation.
12. Blood, blood products, blood derivatives, synthetic blood products, and the administration thereof.
13. Care and treatment for any condition for which state or local laws require treatment in a state or local government facility.
14. Care and treatment for injuries sustained while the Member is under the influence of any illegal or illicit drug, or any controlled or legend drug or substance if the drug or substance is not then subject to a valid prescription issued in the name of the Member by a Plan Physician and being administered to treat a current episode of illness.
15. Care and treatment for military-service connected disabilities for which the Member receives or is paid benefits for which the care and treatment available to the Member from military or other federal, state, or local facilities, contractors, or programs, except as otherwise required by law.
16. Care and treatment incurred in connection with injuries which occurred during a crime committed by a Member or which the Member tries to commit whether or not the Member is charged with or convicted of any criminal offense.
17. Care and treatment or treatment incurred in connection with any injuries sustained by a Member when the Member's blood alcohol content is in excess of the legal limit whether or not the Member is charged or convicted of any criminal offense.



18. Care for Conditions that are required by State or Local law to be treated in a public facility or care for Conditions that are paid under Workers' Compensation or any other third-party-payor who has primary responsibility.
19. Care for illness, injury, complications, and conditions resulting from the provision of non-Covered Services.
20. Circumcisions.
21. Contraceptive devices and supplies, including but not limited to oral contraceptives, IUD's, NorPlant, sterilization procedures, diaphragms, spermicidal suppositories, including the fitting, insertion and removal of such devices.
22. Cosmetic surgical and non-surgical procedures and complications from such procedures.
23. Custodial, respite, domiciliary, rest, or convalescent care, and care and treatment in extended care facilities, boarding homes, long-term home health care nursing services, residential treatment facilities, and adult congregate living facilities, homemaker services and services primarily for rest and any services or supplies rendered by, through or on behalf of any of these facilities.
24. Dental care, surgical and non-surgical treatments, services and supplies.
25. Durable Medical Equipment.
26. Expenses for services provided by someone who ordinarily resides in the Member's home or who is a relative of the Member.
27. Expenses incurred in connection with any self-inflicted wound, injury, illness or condition, whether sane or insane.
28. Experimental and investigative treatment (as defined in this Contract).
29. Eye Care, including the purchase, examination or fitting of eyeglasses or contact lenses; eye surgery or training or orthoptics, including eye exercises.
30. Furnishing, fitting, installation, or use of corrective appliances, prosthetic or orthotic devices, artificial joints, braces, artificial aids, orthopedic shoes.
31. Furnishing, fitting, installing, replacing or repairing, or use of, corrective appliances, braces, artificial aids, blood pressure kits, artificial limbs, and all prosthetics and orthotics.
32. Gene therapy.
33. Genetic counseling, treatment, services and supplies.
34. Health care services rendered by a non-Plan provider or facility.
35. Hearing aids (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers.
36. Hemodialysis, radiation therapy and chemotherapy.
37. Home infusion therapy.
38. Hypnotism or hypnotic anesthesia.
39. Infertility treatment, service and supplies.
40. Injectable syringes and needles and injectable medication.



41. Inpatient or Outpatient Mental health services and treatment of psychiatric conditions that are considered chronic or organic in nature, including services associated with any court ordered care, treatment or any other imposed treatment according to state statutes.(i.e., Baker Act.)
42. Inpatient or outpatient services and treatment for alcohol and substance abuse.
43. Inpatient treatment, procedures, supplies and services, including services requiring spinal or general anesthesia, provided while the Member is an inpatient in a hospital or another inpatient facility.
44. Items and services for which the Member has no legal obligation to pay.
45. Long-term rehabilitative services. All short-term outpatient rehabilitation services are excluded except for those services specifically set forth in the Covered Services section.
46. Massage services
47. Maternity care including childbirth, complications of pregnancy, and termination of pregnancy whether voluntary or involuntary.
48. Medical air or ground transportation services.
49. Non-prescription drugs, including any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.
50. Nursing care at home, home monitoring devices, meals delivered to the home, homemaker services, Physician house calls, and other care provided in the home.
51. Prescription drugs and medicines prescribed by any Physician on an outpatient basis and dispensed at a pharmacy.
52. Pumps, including but not limited to insulin, except when required by state or federal law.
53. Private duty nursing care.
54. Reversal of voluntary, surgically induced sterility including the reversal of tubal ligations and vasectomies, including related medications.
55. Routine foot care such as services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic foot complaints, unless in the judgment of a physician, such care is required due to a Member's medical condition affecting the feet, such as sever diabetes or peripheral vascular disease.
56. Services and supplies for the treatment of an illness or injury resulting from war or an act of war, whether declared or not, or services in the armed forces, or participating in any act which would constitute a riot or rebellion,, or engaging in an illegal occupation.
57. Services of psychiatrists, psychologists, mental health counselors, pastoral counselors, clinical psychologists, and marital, family and child counselors.
58. Services provided while the Member is an outpatient in a hospital, ambulatory surgical facility, or other similar facility including a hospital emergency room.
59. Services to any Member incarcerated at the time of service.
60. Services, supplies, medication, care and treatment for impotence.
61. Sexual reassignment or modification services, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
62. Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs, nicotine products, and prescription drugs (e.g. Zyban).
63. Special education and treatment for mental retardation and mental deficiency.



64. Surgical procedures other than minor surgical procedures performed in a Plan Physician's office.
65. Unless otherwise covered as a benefit, reports, evaluations or physical examinations not required for health reasons, including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluation.
66. Voluntary family planning and related drug therapy including, without limitation, supplies and devices. Voluntary sterilization procedures including tubal ligation and vasectomy are also excluded from coverage.
67. Weight control services, including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program, appetite suppressants, dietary regimens, food or food supplements, exercise programs and equipment or any other dietary regimen or treatment for obesity or reducing or controlling weight.
68. Wigs or cranial prosthesis
69. Work-related condition services to the extent the Member is paid or receives compensation required by Workers' Compensation law.