Exhibit 2

SCI BENEFIT PACKAGE

The benefit package includes provider and consultation services and supplies that are reasonably required to maintain good health and are provided by or under the direction of the member's PCP. The following provides additional information on covered provider services and associated co-payments:

Provider Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Office visits	$0, $5 or $7 per visit
Home visits	$0, $5 or $7 per visit
Hospital and inpatient physical rehabilitation facility visits by physician	None
Inpatient and outpatient surgery (includes assistant surgeon's charges)	Covered as part of facility co-payment
Office procedure	Covered as part of office visit co-payment
Inpatient professional care services of providers including pathologists, radiologists and anesthesiologists	None
Allergy testing	Office visit co-payment
Allergy injections	Part of office visit co-payment
Antigen serum	Office visit co-payment
Injections in accordance with accepted medical practice to treat acute conditions, which are customarily administered in a provider's office	Covered as part of office visit co-payment
Injections in accordance with acceptable medical practice used to treat chronic conditions including, but not limited to diseases such as rheumatoid arthritis, Crohn's Disease, and Hepatitis C	Covered as part of office visit co-payment
Routine and diagnostic X-rays and clinical laboratory tests	None

Inpatient Hospital Services

The benefit package includes inpatient hospital services as detailed in the table below. The table also includes required co-payments.

A. Hospital admissions must be prior authorized and are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP. Any service or procedure not outlined below requires a prior authorization.

B. Inpatient hospitalization coverage is limited to twenty-five (25) days per benefit year. This twenty-five (25)-day limitation is combined with home health services and inpatient physical rehabilitation.

Inpatient Hospital Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Inpatient Hospital Services including: 1. Semi-private room and board accommodations, including general duty nursing care. 2. Private room and board accommodations when medically necessary - prior authorization is required. 3. In-hospital therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units. 4. Use of all hospital facilities, including operating, delivery, recovery, and treatment rooms and equipment. 5. Laboratory tests, x-rays, electrocardiograms (EKGs), electroencephalograms (EEGs), and other diagnostic tests performed in conjunction with a member's admission to a hospital. 6. Anesthetics, oxygen, pharmaceuticals, medications, and other biologicals. 7. Dressings, casts, and special equipment when supplied by the hospital for use in the hospital. 8. Inpatient meals and special diets. 9. Inpatient radiation therapy and/or inhalation therapy. 10. Rehabilitative services – physical, occupational, and speech therapy. 11. Administration of whole blood, blood plasma, and components. 12. Discharge planning and coordination of services	$0, $25, $30 per admission
Maternity care	$0, $25, $30 per admission

Outpatient Services

The benefit package includes outpatient services performed in a hospital or other approved outpatient facility. Outpatient services:

A. Can reasonably be provided on an ambulatory basis.

B. Are preventive, diagnostic or treatment procedures provided under the direction of the member's PCP or a consulting provider to whom the member is referred.

C. Require prior authorization, unless otherwise noted.

Exhibit 2

The following provides additional information on covered outpatient services and associated co-payments:

Outpatient Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Surgeries, including use of operating, delivery, recovery, treatment rooms, equipment and supplies including anesthesia, dressings and medications	$0, $5 or $7 per procedure
Radiation therapy and chemotherapy	$0, $5 or $7 per visit
Magnetic Resonance Imaging (MRI)	$0, $5 or $7 per visit
Positron Emission Tomography (PET) tests	$0, $5 or $7 per visit
CT scan	$0, $5 or $7 per visit
Holter monitors and cardiac event monitors	None
Routine and diagnostic X-rays, clinical laboratory tests, electrocardiograms (EKGs), and electroencephalograms (EEGs)	None
Cardiovascular rehabilitation	$0, $5 or $7 per visit
Rehabilitative services – physical, occupational, and speech therapy Rehabilitative services for short-term physical, occupational, and speech therapies are covered. Short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment. The member's PCP or other appropriate treating provider to whom the member has been referred must determine in advance of rehabilitative services that these services can be expected to result in significant improvement in the member's physical condition within a period of two months. Requests for rehabilitative services from therapists will not be approved. These services must be requested by the ordering provider and require a prior authorization. Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, dependent on the approval of the MCO'S medical director, only if such services can be expected to result in continued significant improvement of the member's physical condition within the extension period. Expectation of significant improvement will be established if the member has complied fully with the instructions for care and has met all therapy goals for the preceding two month period as documented in the therapy record. Therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered under SCI. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitative services produce minimal or temporary change or relief. Chronic conditions include, but are not	$0, $5 or $7 per visit

Outpatient Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
limited to, muscular dystrophy, cerebral palsy, developmental delay, myofascial pain disorders, arthritis, autism, and syndromes of chromosomal abnormalities.	

Emergency and Urgently Needed Health Services

The benefit package includes emergency and urgently needed health services. These services are available twenty-four (24) hours per day, seven (7) days per week. Emergency services are determined using the Prudent layperson standard: when a member, acting in good faith and possessing average knowledge of health and medicine, seeks medical care for what reasonably appears to the member to be an acute situation that requires immediate medical attention, even if the member's condition is subsequently determined to be non-emergent. The benefit package includes inpatient and outpatient services meeting the definition of emergency services, which must be provided without regard to prior authorization or the provider's contractual relationship with the MCO. If the services are needed immediately and the time necessary to transport the member to a network provider would mean risk of permanent damage to the member's health, emergency services must be available through a facility or provider participating in the MCO/SE network or from a facility or provider not participating in the MCO/SE network. Either provider type must be paid for the provision of services on a timely basis. Emergency services include services needed to evaluate and stabilize an emergency medical or behavioral condition. Post stabilization care services means covered services, related to an emergency medical or behavioral condition, that are provided after a member is stabilized in order to maintain this stabilized condition. This coverage may include improving or resolving the member's condition if either the MCO has authorized post-stabilization services in the facility in question, or there has been no authorization; and

(1) the hospital was unable to contact the MCO; or
(2) the hospital contacted the MCO but did not get instructions within an hour of the request. The following provides additional information on covered services and required co-payments.

Emergency and Urgently Needed Health Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Emergency health services can be provided in or out of the service area. Coverage is provided for trauma services at an appropriately designated trauma center according to established emergency medical services triage and transportation protocols. 1. Prior authorization is not required for emergency care.	$0, $15, $20 per visit, waived if admitted to a hospital within 24 hours of emergency room visit

Emergency and Urgently Needed Health Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
2. Coverage for trauma services and all other emergency health services from non-participating providers will continue at least until the member is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending participating provider in consultation with the MCO. The MCO may transfer hospitalized members to the care of participating providers as soon as it is medically appropriate. Such members must be stabilized and the transfer effected in accordance with federal law. 3. The member is responsible for charges for services that are not covered services.	
Use of an urgent care center, where available, in or out of the service area for treatment of sudden unexpected acute illness or injury that requires prompt medical attention to prevent jeopardy to the member that would occur if such services were not received immediately. 1. A non-participating urgent care center may be used only if the member cannot reasonably access a participating provider. 2. Routine or follow-up medical treatment must be provided by or through a participating provider.	$0, $5 or $7 per visit

Women's Health Services

The benefit package includes any gynecological examinations, or care related to pregnancy, for primary and preventive obstetrics, and gynecological services required as a result of any gynecological examination or condition. Covered women's health services may be obtained from the member's PCP, or a participating women's health care provider or a consulting provider to whom the member has been referred by her PCP. The following provides additional information on covered services and required co-payments.

Women's Health Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Office visits	$0, $5 or $7 per visit
Low-dose mammography screening for detection of breast cancer	Included in office visit
Cytological screening to determine the presence of pre-cancerous or cancerous conditions or other health problems	
Services related to the diagnosis, treatment and appropriate management of osteoporosis	
Prenatal and post-partum care: Prenatal care includes a minimum of one prenatal office visit per month during the first two trimesters of pregnancy; two (2) office visits per	None

Women's Health Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
month during the seventh and eight months of pregnancy; and one (1) office visit per week during the ninth month until tremor as medically indicated, provided that coverage for each office visit shall include prenatal counseling and education. Following delivery of a newborn, a female member is entitled to either: 1) post-partum care in the home consisting of up to three visits; or 2) a minimum hospital stay of specified inpatient hours. The choice of either home care or inpatient care will be made based on discussion between the participating provider and the member. If post-partum home care is elected, the care must be rendered in accordance with accepted maternal and neonatal physician assessments, and by a home care participating provider, who is properly licensed, trained and experienced. The member's participating provider may determine that only one (1) or two (2) home visits are sufficient and not require the full three visits allowable. If Inpatient care is elected, a mother and her newly born child in a health care facility will be entitled to a minimum stay of 48 hours after a vaginal delivery or 96 hours following a caesarian section.	
Non-hospital births - Prior authorization is required	$25, $75, $100

Preventive Health Services

The benefit package includes preventive health services. Preventive health services are provided to a member when performed by or under the direction of the member's PCP or a participating provider to whom the member has been referred by his PCP and are consistent with the MCO's preventive health guidelines. There are no co-payments associated with the preventive services listed below. The following provides additional information on covered preventive services.

Preventive Health Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Physical exams, including health appraisal exams, laboratory and radiological tests, hearing and vision screenings, and early detection procedures provided	$0 per visit
Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or a fractionated cholesterol level	Covered as part of office visit

Exhibit 2

Preventive Health Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Periodic glaucoma eye test for all persons thirty-five (35) years of age and older	
Periodic stool examination for the presence of blood for all persons 40 years of age or older	
Periodic Mammograms for detection of breast cancer as follows: one low dose baseline mammogram for women ages 35 through 39, one low dose mammogram biennially for women ages 40 through 49 and one low dose mammogram annually for women over age 50.	
All members may receive an annual consultation to discuss lifestyle behaviors that promote health and well being. Included in the consultation may be, but are not limited to: 1. Smoking control; 2. Nutrition and diet recommendations; 3. Exercise plans; 4. Lower back protection; 5. Immunization practices; 6. Breast self-examinations; 7. Testicular self-examinations; or 8. Use of seat belts in motor vehicles.	
Adult immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP)	
Periodic colon examination of thirty-five (35) to sixty (60) centimeters and/or barium enema for all persons forty-five (45) years of age or older	
Voluntary family planning services	Covered as part of office visit
Insertion of contraceptive devices	Covered as part of office visit
Removal of contraceptive devices	Covered as part of office visit
Surgical sterilization	Applicable co-payment based on place of service

Dialysis

The benefit package includes dialysis services. The following provides additional information on covered services and required co-payments.

Dialysis Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**

Dialysis Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Long-term hemodialysis and continuous ambulatory peritoneal dialysis (CAPD) is provided with a prior authorization and performed by or under the direction of the member's PCP or a consulting provider to whom the member has been referred by his PCP. The member must advise the MCO of the date the treatment commenced.	None

Inpatient Physical Rehabilitation

The benefit package includes inpatient physical rehabilitation. The following table provides information on required co-payments.

A. Inpatient physical rehabilitation services require prior authorization, and services are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP.

B. Inpatient physical rehabilitation facility coverage is limited to twenty-five (25) days per benefit year. This twenty-five (25)-day limitation is combined with inpatient hospital and home health services.

Inpatient Physical Rehabilitation Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Inpatient Physical Rehabilitation	$0, $25, $30 per day

Home Health Services/Home Intravenous Services

The benefit package includes home health services, which are health services provided to a member confined to his home due to physical illness. The table below following provides additional information on covered services and required co-payments.

A. Home health services and home intravenous services are provided by a home health agency (HHA) at a member's home with a prior authorization and prescribed by the member's PCP or a consulting provider to whom the member is referred by his PCP.

B. Home health services in lieu of hospitalization are limited to twenty-five (25) days per benefit year provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or

the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. This twenty-five (25) day limitation is combined with inpatient hospitalization and inpatient physical rehabilitation.

Home Health Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Services provided by a registered nurse or a licensed practical nurse; by physical, occupational, and respiratory therapists; speech pathologists; and by a home health aide	$0, $5 or $7 per visit
Prescription supplies for the provision of home health services at the time of a home health visit	
Home intravenous services	
Tube feedings as the sole source of nutrition	

Durable Medical Equipment, Medical Supplies, Orthotic Appliances and Prosthetic Devices

The benefit package includes durable medical equipment, medical supplies, orthotic appliances, and prosthetic devices. The table below provides additional information on covered services and required co-payments.

A. Prior authorization is required as designated by MCO.

B. Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices with allowable charges of $200 or more per item, including tax and any shipping charges. Rental price can not exceed purchase price.

Durable Medical Equipment, Medical Supplies, Orthotic Appliances and Prosthetic Devices	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Durable medical equipment that requires a provider's prescription for purchase or rental is covered unless otherwise excluded	$0, $5 or $7 per item
Medical supplies that require a provider's prescription for purchase unless otherwise excluded	
Orthotic appliances that require a provider's prescription for purchase unless otherwise excluded	
Prosthetic devices only when they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth or atrophy necessitates replacement, unless otherwise excluded	

Durable Medical Equipment, Medical Supplies, Orthotic Appliances and Prosthetic Devices	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Breast prostheses and bras required in conjunction with reconstructive surgery, except as limited	
Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to normal wear and/or when necessitated by the body's growth or atrophy	

Ambulance Services

The benefit package includes emergency transport services identified below.

A. When necessary to protect the life of the mother or infant, emergency transport includes transport for medically high-risk pregnant women with an impending delivery to the nearest tertiary care facility.

B. The MCO will not pay more for air ambulance than it would have paid for transportation over the same distance by surface emergency medical transportation services unless the member's health condition renders the utilization of such surface services medically inappropriate.

Ambulance Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Emergency ground ambulance transportation to the nearest facility where emergency care and treatment can be rendered and when provided by a licensed ambulance service	None
Emergency, trauma-related air ambulance transportation - prior authorization is required, when feasible	None

Oral Surgery

The benefit package includes limited oral surgery benefits with prior authorization. The following provides additional information on covered services and required co-payments.

Oral Surgery	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
General dental and oral surgery services with a prior authorization only in conjunction with:	Applicable co-payment based upon place of service

Oral Surgery	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
1. Accidental injury to sound natural teeth, the jaw bones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within seventy-two (72) hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury must be properly documented during the initial treatment. Services must be completed within twelve (12) months of the date of injury. The MCO will require dental x-rays. 2. Surgical procedures to correct non-dental, non-maxillomandibular physiologic conditions that produce demonstrable impairment of function. 3. Removal or biopsy, when pathological examination is required of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth. 4. External incision and drainage of cellulitis; incision of infected accessory sinuses, salivary glands or ducts; removal of stones from salivary ducts. 5. Surgical procedures to correct accidental injuries of the jaws and facial bones, cheeks, lips, tongue, roof and floor of mouth.	

Reconstructive Surgery

The benefit package includes reconstructive surgery as provided below:

Reconstructive Surgery	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders – prior authorization is required. Functional disorder must result from accidental injury or from congenital defects or disease. Prosthetic devices and reconstruction surgery of the affected breast or other breast to produce symmetry related to mastectomy. This coverage includes physical complications of all stages of mastectomy, including lymph edemas. A member is allowed at least forty-eight (48) hours of inpatient care following mastectomy and twenty four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer.	Applicable co-payment based upon place of service

Prescription Drugs

The benefit package includes all generic prescription drugs and brand name drugs included on the MCO's Pharmacy Drug List (PDL). Exceptions to the PDL depend on MCO policy. The following provides information on the required co-payments.

Prescription Drugs	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Prescription drugs- the benefit package includes generic prescription and brand name drugs included on the MCO's PDL. Exceptions to the PDL depend on MCO policy.	$3 Generic and/or Brand Name PDL only

Diabetes Treatment

The benefit package includes diabetes treatment. The MCO will maintain an adequate PDL to provide the resources to members with diabetes; and guarantee reimbursement or coverage for the prescription drug, insulin, supplies, equipment and appliances with a prior authorization described in this subsection within the limits of the MCO. The following provides additional information on covered services and required co-payments.

Diabetes Treatment Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Equipment, supplies and appliances to treat diabetes to include: 1. Blood glucose monitors, including those for the legally blind; 2. Test strips for blood glucose monitors; 3. Visual reading urine and ketone strips; 4. Lancets and lancet devices; 5. Insulin (limit two (2) vials per co-payment); 6. Injection aids, including those adaptable to meet the needs of the legally blind; 7. Syringes; 8. Prescriptive oral agents for controlling blood sugar levels; 9. Medically necessary podiatric appliances for prevention of foot complications associated with diabetes, including therapeutic molded or depth inlay shoes, functional orthotic appliances, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and 10. Glucagon emergency kits.	$3 Generic and/or Brand Name PDL only

Diabetes Treatment Service	**Co-payments based on Federal Poverty Limit Percentage 0-100, 101-150, 151-200**
Diabetes self-management training by a certified, registered or licensed health care professional with recent education in diabetes management, which is limited to: 1. Medically necessary visits upon the diagnosis of diabetes; 2. Visits following a provider diagnosis that represents a significant change in the member's symptoms or condition that warrants changes in the member's self-management; 3. Visits when re-education or refresher training is prescribed by a health care provider with prescribing authority; and 4. Medical nutrition therapy related to diabetes management.	$0, $5, $7 per visit

Behavioral Health and Substance Abuse Services: The benefit package includes behavioral health and substance abuse services. Inpatient behavioral health services are limited to twenty-five (25) days per benefit year with prior authorization**.**

Behavioral Health Service	**Copayment**
Outpatient office visits for mental health evaluation and treatment; injectable forms of Haloperidol or Fluphenazine are included in the office visit copayment. Prior authorization is required for over seven (7) visits.	$0, $5, $7 per visit
Inpatient mental health services provided in a psychiatric hospital or an acute care general hospital - **Prior authorization is required.**	$0, $25, $30 per admission
Substance Abuse Service	
Outpatient substance abuse including visits, detoxification and intensive outpatient care limited to forty two (42) days per benefit year	$0, $5, $7 per visit
Inpatient substance abuse detoxification – P**rior authorization is required**	$0, $25, $30 per admission

Annual Limits on Out of Pocket Expenditures

Out-of-pocket charges for all participants will be limited to 5 percent (5%) of maximum countable family income per benefit year.

Limitations on Coverage

The benefit package is limited to $100,000.00 in benefits payable per member per benefit year. If behavioral health services are provided to the member by the Statewide Entity, this cost will be included in the $100,000.00 per year limit. The State may adjust the $100,000 maximum per benefit year; however, the maximum per benefit year cannot be decreased more than five (5) percent in a single year and the maximum per benefit year cannot be adjusted to an amount less than $100,000.

LIMITATIONS ON COVERAGE

The SCI benefit package is limited to $100,000 in benefits payable per member per benefit year. The State may adjust the $100,000 maximum per benefit year; however, the maximum per benefit year cannot be decreased more than five (5) percent in a single year and the maximum per benefit year cannot be adjusted to an amount less than $100,000.

Covered services are subject to the following conditions and limitations:

(1) **Medically Necessary**:

Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:
(a) are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;
(b) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;
(c) are provided within professionally accepted standards of practice and national guidelines; and
(d) are required to meet the physical, mental and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

(2) **Behavioral Health and Substance Abuse Services:**

a. Inpatient mental health services/partial hospitalizations are limited to twenty-five (25) days per benefit year.
b. Inpatient substance abuse detoxification is limited to 72 hours per occurrence as part of the total twenty five day benefit for inpatient mental health services.
c. Outpatient substance abuse detoxification services are limited to ten (10) days per benefit year. Substance abuse outpatient services including intensive outpatient services are limited to forty two (42) days per benefit year.

(3) **Cardiovascular Rehabilitation**

Coverage for cardiovascular rehabilitation is limited to a maximum of thirty-six (36) sessions per cardiac event.

(4) **Choice of Provider**

For the purpose of coverage under this policy, the SCI MCO has the right to determine which provider may be used to provide the covered services.

(5) **Contact Lenses or Eyeglasses Following Cataract Surgery**

One complete set of contact lenses or eyeglasses is covered following surgery for the removal of cataracts from one or both eyes. Coverage is not allowed for both contact lenses and eyeglasses. Coverage is limited to one set of contact lenses or eyeglasses per member per surgery. Coverage for materials (contact lenses or eyeglasses) is limited to $300 per surgery. Coverage for contact lenses or eyeglasses is limited to ninety (90) days following surgery for the removal of cataracts. Contact lenses or eyeglasses obtained after the ninety (90)-day period are not covered.

(6) **Dental Services**

In cases of accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within seventy-two (72) hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury must be properly documented during the initial treatment. Services must be completed within twelve (12) months of the date of injury. The MCO will require dental x-rays.

(7) **Detoxification**

Inpatient detoxification is limited to seventy-two (72) hours of inpatient services per occurrence as part of the twenty five day benefit for inpatient behavioral health services. Outpatient detoxification is limited to ten (10) days per benefit year.

(8) **Home Health Services**

Home health services in lieu of hospitalization, or a combination of inpatient hospitalization, home health services and inpatient rehabilitation may not exceed twenty-five (25) days per benefit year, provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. Home health services are subject to periodic review of the continuation of covered services. If home health services can be provided in more than one medically appropriate setting, the MCO may choose the setting for providing the care.

(9) **Inpatient Hospitalization, Home Health Services, Inpatient Rehabilitation**

This policy is limited to maximum of twenty-five (25) combined days per member per benefit year for inpatient hospitalization, home health services and inpatient rehabilitation.

(10) **Major Disasters**

In the event of any major disaster, epidemic, or other circumstance beyond its control, the MCO will render or attempt to arrange covered services with participating providers insofar as practical according to its best judgment and within the limitations of facilities, supplies, pharmaceuticals, and personnel available. Such circumstances include: complete or partial disruption of facilities; war; riot; civil uprising; disability of the MCO personnel; disability of participating providers; or act of terrorism.

(11) **Maximum Benefit Limits**

Maximum benefits allowed under SCI are limited to $100,000 per member per benefit year. The State may adjust the $100,000 maximum per benefit year; however, the maximum per benefit year cannot be decreased more than five (5) percent in a single year and the maximum per benefit year cannot be adjusted to an amount less than $100,000.

(12) **Maternity Transport**

Coverage for transportation where medically necessary to protect the life of the infant or mother, including air transport if indicated for medically high risk pregnant women with an impending delivery of a potentially viable infant to the nearest available tertiary care center.

(13) **Mastectomy and Lymph Node Dissection**

Length of inpatient stay: not less than forty eight (48) hours inpatient stay following a mastectomy and not less than twenty four (24) hours of inpatient care following a lymph node dissection when determined medically appropriate by physician and patient.

(14) **Orthotic Appliances and Prosthetic Devices**

Repair or replacement of orthotic appliances and prosthetic devices due to normal wear is covered.

(15) **Physical, Speech and Occupational Therapy**

Only short-term rehabilitative services are covered. Short-term therapy is limited to no more than two (2) consecutive months per member per condition.

(16) **Post Mastectomy Supplies**

Bras required in conjunction with reconstructive surgery are limited to two (2) per member, per benefit year.

(17) **Prescription Drugs**

Prescription drugs are limited to generic drugs and name brand Prescription Drug List (PDL) drugs as listed on the MCO PDL.

A. For each co-payment amount, quantities are limited to a thirty (30)-day supply or one hundred (100) tablets, whichever is less, per prescription or refill. All other units will be dispensed in a thirty (30)-day supply, with one co-payment required for each of the following quantities:

i. Topical products. The lesser of eighty (80) gm. of cream/ointment or sixty (60) ml. of lotion/solution or the most commonly dispensed trade package size, per co-payment.

ii. Oral liquids. 480 ml. maximum per co-payment.

iii. Inhalers and vials. One (1) co-payment per unit (diabetic insulin exception – two (2) vials of the same type of insulin per co-payment).

iv. Manufacturer's trade package. One (1) co-payment per trade package (i.e. Imitrex, estrogen patches).

v. Mail order drugs are limited to drugs available through the MCO'S mail order distributor.

(18) Transplants – Organ, Bone Marrow, and/or Tissue

A. Organ, bone marrow, and/or tissue transplants are limited to:

i. Heart;

ii. Heart/lung;

iii. Lung;

iv. Liver;

v. Cornea;

vi. Kidney;

vii. Skin;

viii. Bone marrow (allogenic and autologous stem cell rescue only for leukemia, aplastic anemia, Severe Combined Immunodeficiency Disease, Wiskott-Aldrich Syndrome, advanced Hodgkins or non-Hodgkins lymphoma, recurrent or refractory neuroblastoma, and multiple myelomas.

ix. Pancreas (for uremic, insulin-dependent diabetics concurrently receiving a kidney transplant).

B. No other transplant procedures are covered. The MCO has the right to require that transplants be performed at contracted Centers of Excellence if one is available.

C. A member is eligible for coverage for up to two (2) transplants per lifetime. Multiple organ, bone marrow, and/or tissue transplants performed at the same time are considered to be one procedure. All transplant services are limited by the annual benefit limitation per member per benefit year.

SERVICES EXCLUDED FROM THE SCI BENEFIT PACKAGE

SCI does not cover any service or supply not specifically listed in Paragraph 2.5 as a covered service. If a service is not a covered service, then all services performed in conjunction with the non-covered service are not covered as well. The list of exclusions below is not intended to be exhaustive, but is intended to be of assistance to members. If a service is not listed in Paragraph 2.5 as a covered service, then it is not covered regardless of medical necessity. Other services excluded are:

(1) **Services not Coordinated Through a Member's PCP or Lack of a Prior Authorization**

Health services and supplies if not provided by or under the direction of:

A. The member's PCP or a provider to whom the member has been referred by his PCP;

B. A non-participating provider to whom the member has been referred by his PCP, and a prior authorization is in place for those services; or

C. Any services or supplies that require a prior authorization if a prior authorization is not obtained.

Services not Medically Necessary, not Standard Medical Practice, or Experimental

The following services are not covered:

A. Any treatment, procedure, facility, equipment, drug, drug use, device, or supply that is not medically necessary. SCI pays only for medically necessary services furnished by approved providers to eligible recipients. SCI does not cover experimental or investigational medical, surgical, or other health care procedures or treatments, including the use of drugs, biological products, other products or devices except routine patient costs associated with certain Phase I, II, III, and IV cancer clinical trials.

B. Drugs and devices that are not FDA approve, not FDA approved for the proposed use, or which have been voluntarily removed from the market.

C. Medical, surgical, and/or behavioral health procedures, pharmacological regimes, and/or associated health services if they are experimental, under investigation, or generally not standard medical practice.

(3) **Acupuncture and Chiropractic Services**

Acupuncture and chiropractic services are not covered.

(4) **Assistant Surgeon Services**

Payment for assistant surgeon services when an assistant surgeon is not approved by the MCO is not covered.

(5) **Behavioral Health**

The following behavioral health services are not covered: behavioral health services which are rendered in connection with disorders not classified in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Behavioral health services that are not inpatient hospitalizations or outpatient visits including, but not limited to, residential treatment services, treatment foster care, day treatment, and neurobehavioral programs.

(6) **Cosmetic Services**

Cosmetic services are not covered, including but not limited to: surgery, services, or procedures to change family characteristics or conditions due to aging; dermabrasion; scar reconstruction or revision; acne surgery (including excision of scarring and cryotherapy); tattoo removal; orthognathic jaw surgery; services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body; surgical excision or reformation of sagging skin on any part of the body including, but not limited to eyelids, face, neck, abdomen, arms, legs or buttocks; microphlebectomy; sclerotherapy; liposuction; rhinoplasty; otoplasty;; services related to a cosmetic service, or required as a result of a noncovered cosmetic service; surgery required as a result of a noncovered procedure (such as a noncovered organ/tissue transplant or a sex change operation) or additional surgery or treatment required to care for or correct a complication due to a previous cosmetic service; or breast augmentation, reduction mammoplasty, or nipple reconstruction except as related to reconstructive surgery.

(7) **Court Ordered Care**

Court mandated evaluations and treatment that would not be in compliance with the terms and conditions of the MCO contract are not covered.

(8) **Coverage Out of the Service Area**

Coverage while away from service area except for emergency health services and urgently needed health services is not included, unless otherwise covered.

(9) **Custodial Care**

Custodial or home (domestic) care, including services and supplies that can be performed by non-licensed medical personnel to help a member

meet the normal activities of daily living are not covered. Examples of custodial care that are not covered services are:

A. Bathing;

B. Feeding;

C. Preparing meals; and

D. Performing housekeeping tasks.

(10) **Dental Services**

The following dental services are not covered:

A. All general dental services and dental x-rays, including but not limited to:

i. Anesthesia and facility services for dental restoration;

ii. Removal of impacted teeth;

iii. Removal of tori or exostoses;

iv. Procedures involving orthodontic care, the teeth, dental implants and periodontal disease;

v. Artificial devices, surgery on the supporting structures of the teeth, and bone grafts to prepare the mouth for denture wear;

vi. Personalized restorations, cosmetic replacement of serviceable restorations, or materials that are more expensive than necessary to restore damaged teeth; or

vii. Surgical realignment of the jaw structures for functional malocclusion.

B. Orthodontics, endodontics, and dental prosthetics.

C. Orthotic and orthodontic appliances and/or treatment, crowns, bridges, and/or dentures used for the treatment of Craniomandibular and Temporomandibular Joint Disorders.

(11) **Donor Services**

Medical and hospital services of a donor when the recipient of an organ, bone marrow, and/or tissue transplant is not a member, or when the transplant procedure is not a covered service are not included in the benefit package.

(12) **Durable Medical Equipment, Medical Supplies; Prosthetic Devices; Orthotic Appliances**

The following are not included in the benefit package:

A. Durable Medical Equipment, Medical Supplies

i. Equipment that is non-medical in nature such as voice synthesizers or other communication devices, waterbeds, jacuzzi units, hot tubs, whirlpools, swimming pools, exercise equipment, heating pads, or hot water bottles;

ii. Air conditioners, humidifiers, purifiers, or self-help devices, biofeedback equipment, and tens units;

iii. Deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds, when standard equipment is available and adequate to meet functional requirements;

iv. Repairs to equipment that is not owned by the member, or repairs to equipment that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new unit;

v. Comfort or safety items such as bedboards, hospital beds or mattresses, flotation mattresses, bathtub lifts, grab bars, overbed tables, adjustable beds, telephone arms, diapers, underpads;

vi. Sphygmomanometers, stethoscopes, and blood pressure monitors; or

vii. Medical supplies and equipment that can be purchased over the counter such as shower chairs, elevated toilet seats, alcohol pads, and dressing supplies.

B. Prosthetic Devices

i. Prosthetic devices unless they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth or atrophy necessitates replacement;

ii. External prosthetic devices that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing;

iii. Cosmetic coverings for external prosthetic devices;

iv. Repairs of prosthetic devices that are not owned by the member; or

v. Cochlear implants.

C. Orthotic Appliances

i. Accommodative orthotic appliances; orthopedic shoes and shoe orthotic appliances (except when the shoes are attached and an integral part of the brace), arch supports, shoe inserts, special-ordered shoes, custom shoes, built up shoes of any type, and other supportive devices for the feet, except for the management of diabetes as required by law;

ii. Orthopedic appliances that can be purchased over-the-counter; or

iii. Cranial banding services.

iv. Penile prosthesis.

(13) **Eyeglasses and Vision Services**

The following eyeglasses and vision services are not included in the benefit package:

A. Eye refractions, eyeglasses, and contact lenses, and/or the fitting thereof, and routine vision services, except for contact lenses or eyeglasses following cataract surgery; and

B. Surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses, except for intraocular lenses in connection with cataract removal.

(14) **Genetic Testing**

Genetic testing, screening (other than by Triple Serum Test only) and counseling, with the exception of genetic testing for the diagnosis or treatment of a current illness are not included in the benefit package.

(15) **Health Clubs**

Fees for health clubs, spas and exercise programs are not included in the benefit package.

(16) **Hearing Aids**

The purchase of hearing aids, and/or the fitting thereof, associated hearing aid testing, and other artificial aids, is not included except as specifically defined in Paragraph 2.4(6) (Preventive Health Services).

(17) **Hospice Care**

Hospice care is not included in the benefit package.

(18) **Illegal Acts or Crimes**

The following is not covered: Injury or illness sustained during the voluntary participation in a riot or the commission of an illegal act or crime, or while under the influence of alcohol or other drug or controlled substance, which is not prescribed by a provider. For purposes of this Section, a person will be presumed to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the MCO. The limitations of this Section will not apply unless there is a direct causal relationship between the activity described in above, and the illness or injuries sustained.

(19) **Infertility Treatment**

Infertility treatment services are not covered.

(20) **Learning Disorders**

Special education, counseling, therapy, diagnostic testing, or treatment for learning disorders, whether or not associated with a mental disorder, retardation, or other disturbance, are not included in the benefit package.

(21) **Missed Appointments**

Costs incurred in conjunction with missed appointments are not included in the benefit package.

(22) **Modifications, Improvements, Equipment**

Home, workplace, and automobile modifications, improvements, or equipment are not included in the benefit package.

(23) **No Legal Obligation to Pay**

The following are not included in the benefit package:

A. Services a member is eligible to receive and has received under any governmental program which in the absence of any health services or insurance plan, no charge would be made to the member; and

B. Services or supplies for which the member has no legal obligation to pay or for which no charge would be made if the member were not eligible for SCI.

(24) **Paternity Tests**

Diagnostic tests to establish paternity of a child or unborn child are not included in the benefit package.

(25) **Physical Examinations**

The following physical examinations are not included in the benefit package:

A. Routine physical examinations, vaccinations, and/or immunizations if given for

   i. The purpose of obtaining employment, insurance, passports, or travel; or

   ii. For the purpose of medical research.

B. Sports and school physicals, unless done in conjunction with periodic health assessments.

(26) **Physical, Speech, Occupational Therapy – Long Term**

All long-term physical, speech and occupational therapy services are not included in the benefit package.

(27) **Physical, Speech, Occupational Therapies**

Physical, speech, occupational therapies for the following conditions are not covered:

A. Psychosocial speech delay including delayed language development and developmental apraxia;

B. Mental retardation, down syndrome, autism, autism spectrum disorders, or dyslexia;

C. Syndromes associates with diagnosed disorders attributed to perceptual and conceptual dysfunctions;

D. Learning disabilities, developmental articulation and language disorders, and stuttering; and

E. Sensory disorders (oral and tactile aversions).

(28) **Podiatry and Foot Care**

The benefit package does not include podiatry or foot care, including but not limited to: bunion treatment, callus treatment, corn paring or excision, toenail trimming, except in the treatment of insulin-dependent diabetics. Foot massage of any type, treatment of fallen arches, flat or pronated feet, and shock wave treatment are not included in the benefit package.

(29) **Prenatal, Delivery, Post-partum Services**

A. All services related to the prenatal period: delivery and post-partum, must be received in the MCO service area.
B. Tests to determine the gender of an unborn child are excluded from coverage.

(30) **Prescription Drugs**

The following are excluded from coverage:

A. Brand name non-PDL prescription drugs without prior approval;

B. Drugs which do not require a physician's prescription; except insulin;

C. Contraceptive jellies, creams, foams, devices or implants (except legend contraceptive devices);

D. Therapeutic devices or appliances;

E. Drugs whose sole purpose is to promote or stimulate hair growth (i.e., Rogaine®, Propecia®) or for cosmetic purposes only (i.e., Renova®);

F. Biologicals, blood or blood plasma products;

G. Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;

H. Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member;

I. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution, which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

J. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order; and

K. Charges for the administration or injection of any drug.

(31) **Pulmonary Rehabilitation**

Pulmonary rehabilitation is not included in the benefit package.

(32) **Recovery**

Services, supplies that are otherwise covered to the extent that a member realizes a recovery from any source are not included in the benefit package.

(33) **Repair or Replacement for Lost, Stolen, or Damaged Items**

Repair or replacement for lost, stolen, or damaged items listed below are not included in the benefit package:

A. Durable medical equipment;

B. Medical supplies;

C. Orthotic appliances;

D. Prosthetic devices; and

E. Prescription drugs.

(34) **Services, Supplies for Excluded Services**

Services, supplies, or drugs used for non-covered or excluded procedures or treatment, or used for any related complication(s) are not included in the benefit package.

(35) **Services, Supplies not Primarily Medical**

Services, supplies, and self-help items that are not primarily medical in nature, for personal comfort or safety, convenience or beautification during an inpatient stay, or in the home setting are not covered. Examples include but are not limited to: facial tissues, shampoo, diapers, under pads, grab bars, and exercise equipment.

(36) **Sex Transformation**

Sex transformation surgery and all expenses in connection with such surgery are not included in the benefit package.

(37) **Sexual Dysfunction**

Treatment for sexual dysfunction, including medication, counseling, and clinics is not included in the benefit package.

(38) **Skilled Nursing Facilities**

Skilled nursing facilities are excluded from the SCI benefit package except for admissions to a step-down unit for post acute inpatient treatment for purposes of rehabilitation.

(39) **Sterilization Reversal**

Treatment for sexual dysfunction, including medication, counseling, and clinics, is not included in the benefit package**.**

(40) **Substance Abuse and/or Tobacco Use**

Treatment to prevent the following is not included in the benefit package:

A. Inpatient substance abuse treatment other than detoxification; and

B. Nicotine medications, gums, services, or supplies to aid in the treatment of addiction to tobacco or tobacco products. Nicotine withdrawal treatments including hypnosis, biofeedback, guided imagery, and other forms of relaxation training or subliminal suggestions used to modify tobacco use.

(41) **Therapies**

Therapies including, but not limited to: exercise, massage, hypnotherapy, sensory, hippo, aquatic, oral aversion, visual training, recreational, sleep, stress management, scream, and myotherapy are not included in the benefit package.

(42) **Travel/Lodging Expenses**

Travel and lodging expenses are not included in the benefit package.

(43) **Vocational Rehabilitation Services**

Vocational rehabilitation services are not included in the benefit package.

(44) **War, Terrorism, Armed Forces**

Any illness and/or injury resulting from war, act of terrorism, or an act of war or service in the armed forces of any country are not included in the benefit package, to the extent covered services of such illness and/or injury are provided through any governmental plan or program.

(45) **Weight Loss**

Surgery, medications, and related services for the purpose of weight reduction or control are not included in the benefit package.

(46) **Worker's Compensation**

Industrial, work-related, or occupational illnesses, injuries, or conditions subject to federal, state, or other worker's compensation or liability law or other legislation of similar purpose are not included in the benefit package, unless the group is an employer not subject to the New Mexico Worker's Compensation Act or similar legislation.

(47) **Miscellaneous**

The following miscellaneous items are not included in the benefit package:

A. Charges associated with copying or transferring of health information;

B. Consultations by environmental engineers;

C. Devices, medications, and treatments to remove hair due to excessive hair growth;

D. Holistic medicine and/or biofeedback;

E. Treatments, medications, prosthetic devices, and orthotic appliances to treat hair loss;

F. Bone density screening with ultrasound devices; and

G. Telephone visits by a provider or environmental intervention or consultation by telephone for which a charge is made to the member, and getting acquainted visits without physical assessment or diagnostic or therapeutic intervention provided.