

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
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1937(a),
1937(b)

The State elects to provide alternative benefits under Section 1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

- a. Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

Family Choices which means children covered pursuant to: Sections 1902 (a)(10)(A)(i)(I) and 1931 of the Act

Sections 1902(a)(52) and 1925 of the Act (Excluding children eligible under Part A or E of title IV)

Sections 1902 (a)(10)(A)(i)(IV) as described in 1902 (I)(1)(B) of the Act

Sections 1902 (a)(10)(A)(i)(VI) as described in 1902 (I)(1)(C) of the Act

Sections 1902 (a)(10)(A)(i)(VII) as described in 1902 (I)(1)(D) of the Act

42 CFR 457.310

- b. Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

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List the populations/individuals who will be offered opt-in alternative coverage:

Comprehensive Choices

The Comprehensive Choices package will be available to all individuals who meet the nursing facility level of care and receive services through either a nursing facility or one of the following 1915 c waivers: Acquired Brain Injury, Home and Community Based or Model II.

Comprehensive Choices EG 4	Federal Poverty Level
Mandatory State Plan Populations	
Aged individuals who receive SSI and meet NF level of care and are in hospice	Up to 74%
Disabled individuals who receive SSI and meet NF level of care and are in hospice	Up to 74%
Non-Mandatory State Plan Populations	
Aged individuals who do not receive SSI and meet NF level of care	Up to 221 %
Disabled individuals who do not receive SSI and meet NF level of care, including those served by the ABI waiver	Up to 221 %
Aged individuals who do not receive SSI and meet NF level of care and are in hospice	Up to 221 %
Disabled individuals who do not receive SSI and meet NF level of care and are in hospice	Up to 221 %

Optimum Choices

The Optimum Choices package will be available to all individuals who meet the intermediate care facility for individuals with mental retardation or a developmental disability level of care and receive services through either an intermediate care facility for individuals with mental retardation or a developmental disability or through the 1915 c Supports for Community Living waiver.

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Optimum Choices EG 4	Federal Poverty Level
Mandatory State Plan Populations	
Aged individuals who receive SSI and meet ICF MR DD level of care and are in hospice	Up to 74%
Disabled individuals who receive SSI and meet ICF MR DD level of care and are in hospice	Up to 74%
Non-Mandatory State Plan Populations	
Aged individuals who do not receive SSI and meet ICF MR DD level of care	Up to 221%
Disabled individuals who do not receive SSI and meet ICF MR DD level of care	Up to 221%
Aged individuals who do not receive SSI and meet ICF MR DD level of care and are in hospice	Up to 221%
Disabled individuals who do not receive SSI and meet ICF MR DD level of care and are in hospice	Up to 221%

Employer Sponsored Insurance (ESI):

Except for the following exclusions, ESI will be available to all members who elect ESI coverage. Individuals excluded from the ESI option include all children, including but not limited to, those covered pursuant to:

- Section 1634(c) and 1634(d)(2) of the Act;**
- Sections 1902(a)(10)(A)(i)(I) and 1931 of the Act;**
- Section 1902(a)(10)(A)(i)(II) of the Act;**
- Sections 1902(a)(10)(A)(i)(IV) as described in 1902 (l)(1)(B) of the Act;**
- Sections 1902(a)(10)(A)(i)(VI) as described in 1902 (l)(1)(C) of the Act;**
- Sections 1902(a)(10)(A)(i)(VII) as described in 1902 (l)(1)(D) of the Act;**

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Sections 1902(a)(52) and 1925 of the Act; 42 CFR
435.120, 435.134, 435.135, 435.137, 435.138,
435.145, 435.227, 435.320, 435.322, and 435.324;
42 CFR 457.310

Individuals who voluntarily elect ESI coverage will be subject to the benefit package, cost sharing and co-payment provisions of the ESI. The ESI benchmark equivalent plan will be the Kentucky State Employee Essential Health Insurance Plan (please see Appendix 1 to Attachment 3.1-C). Kentucky Medicaid will not provide wrap around services to individuals enrolled in ESI. For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

The State will send to each eligible member a letter notifying them of the benefits and cost sharing associated with participation in the Comprehensive Choices and Optimum Choices benefit packages. The cost sharing under the Comprehensive Choices plan and the Optimum Choices plan is less than the cost sharing under the Global Choices plan due to the unique level of care.

The State will send to each eligible member a letter notifying them of the Employer Sponsored Insurance option. When an individual initially applies for Kentucky Medicaid or applies for recertification, the

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eligibility intake worker will offer the individual the opportunity to opt in to Employer Sponsored Insurance. The worker will provide informational materials to the individual explaining ESI and noting that the ESI may offer less benefits than those offered via the traditional Medicaid benefit package. The material shall contain a statement that the individual may opt out of the ESI plan at any time and revert back to appropriate Medicaid coverage.

If the individual elects ESI coverage, he/she will be asked to sign appropriate documentation denoting his/her election and the eligibility worker will request a copy of the individual's ESI plan Schedule of Benefits.

The worker will forward the ESI Schedule of Benefits along with the individual's ESI opt-in form to the Medicaid contractor that administers the State's Health Insurance Premium Plan (HIPP) program for the State. The contractor will determine if the benefits offered under the ESI plan are equivalent to the benchmark plan and if the plan is cost effective and meets economy and efficiency principles.

If the ESI plan benefits equal the benchmark plan benefits, is cost effective for the State and meets economy and efficiency principles a letter will be sent to the individual accepting their request to opt in to the ESI plan. If the ESI plan fails to meet the above tests, the individual will be sent a letter notifying that their request

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for ESI was not accepted due to failing to meet whichever criteria it did not meet. Thus, the State will ultimately maintain discretion as to whether or not to offer ESI coverage to an individual.

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

Please see the attached benefit grid for Comprehensive Choice and Optimum Choices. Cost sharing for this population is reduced under this benefit design.

The Kentucky State Employee Essential Health Insurance Plan (please see attached) will be the benchmark equivalent plan utilized for individuals selecting Employer Sponsored Insurance.

c. Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

Targeted disease management benefits will be made available to certain counties based on diagnosis of applicable disease state.

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography

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limitations, or any other requirements or limitations.
Please see the attached listing of disease management program descriptions and their corresponding geographic locations. All Medicaid eligibles with an appropriate diagnosis code, who are capable of meeting the participation requirements of the related disease management program, may elect to participate in the disease management program if offered in their county of residence. All enrollments will be opt-in, participation will not be mandated.

B. Description of the Benefits

The State will provide the following alternative benefit packages (check all that apply).

1937(b)

1. Benchmark Benefits

a. **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

b. **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State's employee benefits plan package.

c. **Coverage Offered Through a Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has

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the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO's benefit package.

d. X / **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

Please see the attached Family Choices benefit description, Comprehensive Choices benefit description, Optimum Choices benefit description and Disease Management program descriptions.

2. X / **Benchmark-Equivalent Benefits**. Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan: **The Employer Sponsored Insurance (ESI) plan will be equivalent to the State's State Employee Essential Health Insurance Plan which is attached.**

The State will send to each eligible member a letter notifying them of the Employer Sponsored Insurance option. When an individual initially applies for Kentucky Medicaid or applies for recertification, the eligibility intake worker will offer the individual the opportunity to opt in to Employer Sponsored Insurance. The worker will provide informational materials to the individual explaining ESI and noting that the ESI may

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offer less benefits than those offered via the traditional Medicaid benefit package. The material shall contain a statement that the individual may opt out of the ESI plan at any time and revert back to appropriate Medicaid coverage.

If the individual elects ESI coverage, he/she will be asked to sign appropriate documentation denoting his/her election and the eligibility worker will request a copy of the individual's ESI plan Schedule of Benefits.

The worker will forward the ESI Schedule of Benefits along with the individual's ESI opt-in form to the Medicaid contractor that administers the State's Health Insurance Premium Plan (HIPP) program for the State. The contractor will determine if the benefits offered under the ESI plan are equivalent to the benchmark plan and if the plan is cost effective and meets economy and efficiency principles.

If the ESI plan benefits equal the benchmark plan benefits, is cost effective for the State and meets economy and efficiency principles a letter will be sent to the individual accepting their request to opt in to the ESI plan. If the ESI plan fails to meet the above tests, the individual will be sent a letter notifying that their request for ESI was not accepted due to failing to meet whichever criteria it did not meet. Thus, the State will ultimately maintain discretion as to whether or not to offer ESI coverage to an individual.

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a. X / The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

b. X / The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of

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that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. X / The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) / **Inclusion of Basic Services** – This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

/ Inpatient and outpatient hospital services;

/ Physicians' surgical and medical services;

/ Laboratory and x-ray services;

/ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices

/ Other appropriate preventive services, as designated by the Secretary.

/ Clinic services (including health center services) and other ambulatory health care services.

/ Federally qualified health care services

/ Rural health clinic services

/ Prescription drugs

/ Over-the-counter medications

/ Prenatal care and pre-pregnancy family services and Supplies

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- / Inpatient Mental Health Services not to exceed 30 days in a calendar year
- / Outpatient mental health services furnished in a State-operated facility and including community-based services
- / Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
- / Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
- / Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year
- / Dental services
- / Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
- / Outpatient substance abuse treatment services
- / Case management services
- / Care coordination services
- / Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- / Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.
- / Premiums for private health care insurance coverage
- / Medical transportation
- / Enabling services (such as transportation, translation, and outreach services
- / Any other health care services or items specified by the Secretary and not included under this section

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The State will maintain a list of all services covered by each ESI plan utilized by individuals who voluntarily select ESI coverage.

- (2) Additional benefits for voluntary opt-in populations:
 / Home and community-based health care services
 / Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

Please see attached Kentucky state employee benefit grid and the table outlining the differences between that plan and Family Choices.

3. Wrap-around/Additional Services

- a. / The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

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EPSDT services will be provided by the State to insure that the full EPSDT benefit is available when medically necessary.

b. ___ / The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

Check all that apply.

1. ___ / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.
2. ___ / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).
3. ___ / The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirement.
4. ___ / Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

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5. X / Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

At the inception of the Family Choices program, the alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).

Post implementation the State intends to bid out the plan to be administered through a managed care entity.

Premium assistance will be provided to recipients opting into employer sponsored insurance coverage with benchmark-equivalent benefits.

D. Additional Assurances

- a. X / The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).
- b. X / The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

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E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

X / The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

X / The State will implement this State Plan amendment on May 15, 2006.

H. Signature

Date: 4-19-06

Authorizing Official: Shannon Turner, JD
Commissioner

Authorizing Official's
Signature: _____

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Family Choices Attachments

The Family Choices benefit package was based on the Kentucky state employee benefit package with modifications to assure nominal cost sharing. Some benefit limit and design changes were also made to the package. Limits imposed under the Family Choices plan are soft limits which means additional visits may be authorized if medically necessary; in contrast, the limits in the state employee health benefit plan are hard limits and may not be exceeded. The differences are detailed in the following table:

State Employee Benefit	Family Choices Benefit
Chiropractic Services- 26 per visits per year	Chiropractic Services- 7 visits per 12 months
Speech Therapy- 30 visits per year	Speech Therapy- 15 visits per year
Physical Therapy- 30 visits per year	Physical Therapy- 15 visits per year
Occupational Therapy- 30 visits per year	Occupational Therapy- 15 visits per year
EPSDT (not fully covered)	EPSDT
Home Health- limited to 60 visits per year	Home Health- 25 visits per 12 months
Skilled Nursing Facility Services- limited to 30 days per year	Skilled Nursing Facility Services- no day limitation

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The Following table outlines the benefit package for Family Choices. The cost sharing requirements listed in this benefit grid will apply to all members of Family Choices. For the Family Choices populations, these cost sharing requirements shall supersede any other cost sharing requirements described elsewhere in the state plan.

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children
Medical Out-of-Pocket Maximum	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months
Pharmacy Out-of-Pocket Maximum	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months
Acute Inpatient and Critical Access Hospital Services	\$0 co-pay	\$0 co-pay	\$0 co-pay
Laboratory, Radiology and Diagnostic Physician Services	\$0 co-pay	\$0 co-pay	\$0 co-pay
EPSDT Services for Children under 21	\$0 co-pay	\$0 co-pay	Not covered
Outpatient Hospital/Ambulatory Surgical Centers	\$0 co-pay	\$0 co-pay	\$0 co-pay
Behavioral Health Services	\$0 co-pay	\$0 co-pay	\$0 co-pay
Allergy Services	• \$0 co-pay	• \$0 co-pay	• \$2 co-pay for office visit and testing • \$0 co-pay for injections
Preventive Services	\$0 co-pay	\$0 co-pay	\$0 co-pay
Emergency Ambulance	\$0 co-pay	\$0 co-pay	\$0 co-pay

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Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children
Dental Services Including but not limited to Children under 21, two cleanings per 12 months, one set of x-rays per 12 months, extractions.	\$0 co-pay	\$0 co-pay	\$0 co-pay
Family Planning	\$0 co-pay	\$0 co-pay	\$0 co-pay
Occupational Therapy	\$0 co-pay 15 visits per 12 months for each therapy	\$0 co-pay 15 visits per 12 months for each therapy	\$0 co-pay 15 visits per 12 months for each therapy
Physical Therapy	\$0 co-pay 15 visits per 12 months for each therapy	\$0 co-pay 15 visits per 12 months for each therapy	\$0 co-pay 15 visits per 12 months for each therapy
Speech Therapy	\$0 co-pay 15 visits per 12 months	\$0 co-pay 15 visits per 12 months	\$0 co-pay 15 visits per 12 months
Hospice (non-institutional)	\$0 co-pay	\$0 co-pay	\$0 co-pay
Non-Emergency Transportation (will be provided for all groups except BCCTP members as described in the current 1915b waiver)	Not Covered	Not Covered	Not Covered
Chiropractic Services	\$0 co-pay 7 visits per 12 months	\$0 co-pay 7 visits per 12 months	\$0 co-pay 7 visits per 12 months

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Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children
Prescription Drugs	\$0 co-pay	\$0 co-pay	\$1 generic \$2 preferred \$3 non-preferred brand prescriptions
Emergency Room	\$0 co-pay	\$0 co-pay	5% coinsurance for non-emergency use
Hearing Aids and Audiometric Services	\$0 co-pay \$1,400 maximum per ear every 36 months; 1 audiologist visit per 12 months; children under 21 ONLY	\$0 co-pay \$1,400 maximum per ear every 36 months; 1 audiologist visit per 12 months; children under 21 ONLY	\$0 co-pay \$1,400 maximum per ear every 36 months; 1 audiologist visit per 12 months; children under 21 ONLY
Vision Services General ophthalmology and optometry	\$0 co-pay \$400 maximum on eyewear per 12 months; children under 21 ONLY	\$0 co-pay \$400 maximum on eyewear per 12 months; children under 21 ONLY	\$0 co-pay \$400 maximum on eyewear per 12 months; children under 21 ONLY
Prosthetic Devices	\$0 co-pay \$1,500 per 12 months	\$0 co-pay \$1,500 per 12 months	\$0 co-pay \$1,500 per 12 months
Home Health Services	\$0 co-pay 25 visits per 12 months	\$0 co-pay 25 visits per 12 months	\$0 co-pay 25 visits per 12 months

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Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children
DME	\$0 co-pay	\$0 co-pay	\$0 co-pay
Substance Abuse	\$0 co-pay	\$0 co-pay	\$0 co-pay
	EPSDT only	EPSDT only	EPSDT only

* **Physician Services** include physicians, certified pediatric and family nurse practitioners, nurse midwives, FQHCs, rural health clinics and physician assistants.

****Behavioral Health Services** include mental health rehab/stabilization, behavioral support, psychological services and inpatient psychiatric services under the age of 21.

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Comprehensive Choices and Optimum Choices Benefit Plan

The following table outlines the benefit package for Comprehensive Choices and Optimum Choices. The cost sharing requirements listed in this benefit grid will apply to all members of Comprehensive Choices and Optimum Choices. For the Comprehensive Choices and Optimum Choices populations, these cost sharing requirements shall supersede any other cost sharing requirements described elsewhere in the state plan.

Comprehensive Choices and Optimum Choices Cost Sharing & Limits Individuals receiving institutional services will not have co-pays other than their patient responsibility		
Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Medical Out-of-Pocket Maximum	No Maximum	\$225 per 12 months
Pharmacy Out-of-Pocket Maximum	No Maximum	\$225 per 12 months
Acute Inpatient and Critical Access Hospital Services	\$50 co-pay per admission	\$10 co-pay
Outpatient Hospital/Ambulatory Surgical Centers	\$3 co-pay	\$3 co-pay
Laboratory, Radiology and Diagnostic Services	\$0 co-pay	\$0 co-pay
Physician Services*	\$2 co-pay	\$0 co-pay
EPSDT Services for Children under 21	\$0 co-pay	\$0 co-pay
Maternity Services Nurse mid-wife services, pregnancy-related services and services for other conditions that might complicate pregnancy and 60 days postpartum pregnancy related services.	\$0 co-pay	\$0 co-pay
Preventive and Screening Services	\$0 co-pay	\$0 co-pay

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BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Comprehensive Choices and Optimum Choices Cost Sharing & Limits Individuals receiving institutional services will not have co-pays other than their patient responsibility		
Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Durable Medical Equipment	3% coinsurance to maximum of \$15 per month (NF residents' DME are included in NF rate)	3% coinsurance to maximum of \$15 per month (NF residents' DME are included in NF rate)
Podiatry Services	\$2 co-pay	\$2 co-pay
Vision Services General ophthalmology and optometry	\$2 co-pay	\$0 co-pay
		\$400 maximum on eyewear per 12 months; children under 21 ONLY
Dental Services Including but not limited to Children under 21, two cleanings per 12 months, one set of x-rays per 12 months, extractions. Adults 21 and over, one cleaning per 12 months, one set of x-rays and extractions	\$2 co-pay	\$0 co-pay
Family Planning Services and Supplies	\$0 co-pay	\$0 co-pay
Occupational Therapy	\$0 co-pay	\$0 co-pay
		30 visits per 12 months
Physical Therapy	\$0 co-pay	\$0 co-pay
		30 visits per 12 months

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Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Speech, Hearing and Language Therapy	\$0 co-pay	\$0 co-pay 30 visits per 12 months
Hospice (non-institutional)	\$0 co-pay	\$0 co-pay
Behavioral Health Services **	\$0 co-pay	\$0 co-pay
Transportation Services (as described in the current 1915b waiver)	\$0 co-pay	\$0 co-pay
Emergency Ambulance	\$0 co-pay	\$0 co-pay
Chiropractic Services	\$2 co-pay	\$0 co-pay
	Aged 21 & over, 15 visits per 12 months Under 21 years of age, 7 visits per 12 months	Aged 21 & over, 15 visits per 12 months Under 21 years of age, 7 visits per 12 months
Prescription Drugs	For members who do NOT have Medicare Part D: \$1 co-pay generic \$2 co-pay preferred brand 5% coinsurance for non-preferred brand prescriptions	For members who do NOT have Medicare Part D: \$1 co-pay generic \$2 co-pay preferred brand 5% coinsurance for non-preferred brand prescriptions
		Limit of four prescriptions per month; maximum of 3 brand
Emergency Room	5% coinsurance for non-emergent visits	5% coinsurance for non-emergent visits
Hearing and Audiometric Services	\$2 co-pay	\$0 co-pay
		\$1,400 maximum per ear every 36 months; children under 21 ONLY: 1 audiologist visit per 12 months

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Comprehensive Choices and Optimum Choices Cost Sharing & Limits		
Individuals receiving institutional services will not have co-pays other than their patient responsibility		
Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Prosthetic Devices	\$0 co-pay	\$0 co-pay
Home Health Services	\$0 co-pay	\$0 co-pay
End Stage Renal Disease and Transplants	\$0 co-pay	\$0 co-pay

* **Physician Services** include physicians, certified pediatric and family nurse practitioners, nurse midwives, FQHCs, rural health clinics and physician assistants.

****Behavioral Health Services** include mental health rehab/stabilization, behavioral support, psychological services and inpatient psychiatric services under the age of 21.

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