Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 22 - 0009

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Base Benchmark Commercial HMO
Advantage HMO
Basic Plan

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Physician (PCP) Services Office Visit
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Office visit services include supplies for treatment of the illness or injury, medical consultations, procedures performed in the physician's office, second opinion consultations and specialist treatment services provided by a PCP.

For second opinion consultations, the Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Specialty Physician Visits
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Referral Physician Office Visit included.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Home Health Services
Source: Secretary-Approved Other
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit:
100 visits per year

Duration Limit:
None

Scope Limit:
Services covered only if not considered custodial care and are prescribed in writing by a participating physician as medically necessary, in place of inpatient hospital care or convalescent nursing home and services provided under physician's care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services include skilled medical services; nursing care given or supervised by RN; nutritional counseling furnished or supervised by RD; home hospice services; home health aides; laboratory services, drugs, and medicines prescribed by a physician in connection with home health care; and medical social services. Home hospice services are considered a separate service.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Outpatient Surgery

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Outpatient medical and surgical hospital services are covered when medically necessary. Includes diagnostic invasive procedures that may or may not require anesthesia.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Allergy Testing

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes allergy procedures-administration of serum

Remove

Benefit Provided:

Chemotherapy-Outpatient

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes outpatient therapeutic injections which are medically necessary and may not be self-administered. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

IV Infusion Services

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for outpatient infusion therapy.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Alternative Benefit Plan

Remove

Benefit Provided: Radiation Therapy- Outpatient

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for outpatient services.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Dialysis

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage provided for outpatient (including home) dialysis services provided by a participating provider. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Remove

Benefit Provided: Outpatient Services

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes colonoscopy and pacemaker. Benefits provided are PCP, specialty and referral for all physician services in an outpatient facility.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Dental- Limited Covered Services- Accident/Injury

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Treatment complete within 1 year from initiation

Duration Limit:

None

Scope Limit:

Coverage not provided for orthodontia, dental procedures, repair of injury caused by an intrinsic force, such as the force of the upper and lower jaw in chewing, repair of artificial teeth, dentures or bridges and other dental services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Injury to sound and natural teeth including teeth that have been filled, capped or crowned.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, to report injury to insurer and receive follow-up care within specified timeframe, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Urgent Care- Walk-ins

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes after hours care.

Benefit Provided: Routine Foot Care

Source: Secretary-Approved Other

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 6 visits per year

Duration Limit: None

Scope Limit:

Coverage not provided for supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope limit continued- and calluses.
Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Voluntary Sterilization for Males

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Clinical Trials for Cancer Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Items and services that are not routine care costs or unrelated to the care method will not be covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The clinical trial must be approved or funded by one of the following: National Institute of Health; cooperative group of research facilities that have an established peer review program that is approved by a National Institute of Health or center; FDA; United States Department of Veterans Affairs; United States Department of Defense; institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institute of the Office for Human Research Protections; and research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

Coverage provided for routine care costs that are incurred in the course of a clinical trial.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, review of clinical trial to ensure qualified, review of routine costs related to clinical trial and a justification of services rendered for the medical needs of the member.

Add

Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided: Emergency Department Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Medical care provided outside of the U.S. is not covered

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Emergency room included.

Benefit Provided: Emergency Transportation: Ambulance/Air Ambulance

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Other medically necessary ambulance transport (ambulance, medi-van or similar medical ground, air or water transport to or from the hospital or both ways and transfer from a hospital to a lower level of care) is covered.

For other medically necessary transportation, authorization may be required in which the Managed Care Entities (MCEs) may require other details, such as general member information, to contact PCP for other types of transportation related services and a justification of services rendered for the medical needs of the member.

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided: General Inpatient Hospital Care

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; inpatient cardiac rehabilitation and rehabilitation therapy; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, review of medical necessity, authorization by acting physician, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Inpatient Physician Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes PCP, specialty and may require a referral for physician services in the hospital.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Remove

Benefit Provided: Inpatient Surgical Services

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include bariatric surgery, surgical and nonsurgical treatment of TMJ, personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products,

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit continued- and room and board when temporary leave permitted.

Surgical hospital services are covered when medically necessary. Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals.

Surgical operations may include replacement of diseased tissue removed while a member.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Non-cosmetic Reconstructive Surgery

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Services begin within 1 year of the accident

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician. Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Mastectomy- Reconstructive Surgery

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician. Covered services include reconstruction of the breast upon which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Transplants

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a member. No coverage is provided for the donor or the recipient when the recipient is not a member. Specialty Care Physician (SCP) provides pre-transplant evaluation. Non-experimental, non-investigational organ and other transplants are covered. Donor's medical expenses covered if the person receiving the transplant is a member, and donor's expenses are not covered by another issuer.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Congenital Abnormalities

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Anesthesia

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes anesthesia services and supplies.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided: Hospice Care

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Room and board services are not covered when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit may be provided in hospitals, skilled nursing facilities, and freestanding hospice centers. Covered services include semi-private room (private room provided when medically necessary). Hospice care provided if terminal illness, in accordance with a treatment plan before admission to the program. Treatment plan must provide statement from physician that life expectancy is 6 months or less. Concurrent care is provided to children (19 & 20 year olds).

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Medical Social Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospital services to assist member and family in understanding and coping with the emotional and social problems affecting health status.

Benefit Provided: Dialysis

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Inpatient dialysis services provided by a participating provider.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Chemotherapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as

general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided:
Obstetric Care

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits equivalent to State Plan

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage is provided from the State Plan under the physician benefit and includes various obstetrical services such as antepartum and postpartum visits, laboratory and x-ray (ultrasound) services and other services as medically necessary and appropriate. The benefit provides for antepartum services up to 14 visits for normal pregnancies. High-risk pregnancies may allow for additional visits. Postpartum services includes 2 visits within 60 days of delivery.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

Collapse All ☐

■ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Mnetal/Behavioral Health Inpatient

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders; personal comfort items; and room and board when temporary leave available

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include evaluation and treatment in a psychiatric day facility and electroconvulsive therapy. Coverage may also include partial hospitalization depending on the type of services provided.
These services are not provided through institutions of mental disease (IMDs).

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Mental/Behavioral Health Outpatient

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage does not include self-help training or other related forms of non-medical self care; marriage counseling; hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage applies to individual therapy and group therapy sessions. Benefit may also include partial hospitalization depending on the type of services provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as

general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Substance Abuse Inpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: up to 15 days in a calendar month

Duration Limit: None

Scope Limit:

Members 21 through 64 years of age in facilities that qualify as institutions for mental disease. Members can be authorized for up to 15 days in a calendar month.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit does not include services and supplies for the treatment of co-dependency or caffeine addiction; personal comfort items; and room and board when temporary leave permitted.

Benefit includes detoxification for alcohol or other drug addiction. Coverage may also include partial hospitalization depending on the type of services provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Substance Abuse Outpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include services and supplies unrelated to mental health for the treatment of codependency or caffeine addiction.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes detoxification for alcohol or other drug addiction. Benefit may also include partial hospitalization depending on the type of services provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of

treatment.

Add

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The prescription drug benefit will cover at least one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater. The formulary must support the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in 405 IAC 5-24-3. In addition, the exact drugs covered under the formulary may vary by the Managed Care Entities (MCEs). Prescription supply is limited to 90 days.

For authorization, Managed Care Entities may require prior authorization requirements, such as general member information, a justification of need for Rx related to the medical needs of the member and a planned course of treatment, if applicable, as related to the number Rx provided and duration of treatment. Prior authorization requirements for prescription drugs may vary by MCE, but will comply with Mental Health Parity requirements. MCEs will be required to have a process in place to allow drugs that are medically necessary, but not included on the formulary to be accessed by members.

Alternative Benefit Plan

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Physical Therapy, Occupational Therapy, Speech The

Source: Secretary-Approved Other

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 60 combined visits annually.

Duration Limit: None

Scope Limit:

Rehabilitative and habilitative services are offered at parity and have distinct benefit limits. Coverage does not include nonsurgical treatment of TMJ.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 60 combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Remove

Benefit Provided: Durable Medical Equipment (DME)

Source: Secretary-Approved Other

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 15 mo rental cap;1 every 5 yr per member- replac

Duration Limit: None

Scope Limit:

DME does not include corrective shoes, arch supports, dental prostheses, deluxe equipment, common first aid supplies and non-durable supplies. Other non-covered services include but not limited to equipment not suitable for home use.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes but not limited to wheel chairs, crutches, respirators, traction equipment, hospital beds, monitoring devices, oxygen-breathing apparatus and insulin pumps. Training for use of DME is also covered and applicable rental fees. Covered services are only for the basic type of DME necessary to provide for medical needs and does not include non-durable supplies that are not an integral part of the DME set-up.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Prosthetics

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include foot orthotics, devices solely for comfort or convenience and devices from a nonaccredited provider.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A prosthetic device means an artificial arm or leg or any portion thereof. Orthotic devices are also covered under this benefit as custom fabricated braces or supports designed as a component of an artificial arm or leg. Covered services include the purchase, replacement or adjustment of artificial limbs when required due to a change in your physical condition or body size due to normal growth.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Remove

Benefit Provided: Corrective Appliances

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include but not limited to artificial or prosthetic limbs, cochlear implants, dental appliances, dentures, foot orthotics, corrective shoes, arch supports for plantar fasciitis, flat feet, fallen arches and corns.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit must be medically necessary and used to restore function or to replace body parts. Benefit includes but not limited to hemodialysis equipment, breast prostheses, back braces, artificial eyes, one pair eyeglasses due to cataract surgery, ostomy supplies and prosthetics (all prosthetics except prosthetic limbs). Coverage not intended for non-durable appliances.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Cardiac Rehabilitation

Source: Secretary-Approved Other

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 60 combined visits annually.

Duration Limit: None

Scope Limit: Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 60 combined visits annually for PT, OT, ST and pulmonary rehabilitation.

Benefit includes services for the improvement of cardiac disease or dysfunction.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Medical Supplies

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Benefit does not include non-durable supplies and/or convenience items.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes casts, dressings, splints and other devices used for reduction of fractures and dislocations

Benefit Provided: Pulmonary Rehabilitation

Source: Secretary-Approved Other

Remove

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
60 combined visits annually

Duration Limit:
None

Scope Limit:
Benefit does not include formalized and pre-designed rehabilitation programs for pulmonary conditions. Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 60 combined visits annually for PT, OT, ST and cardiac rehabilitation.

Benefit consists of services that are for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent emergency room visits, progressive dyspnea, hypoxemia or hypercapnia. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Skilled Nursing Facility (SNF)

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
100 days per benefit period.

Duration Limit:
None

Scope Limit:
A SNF does not include any institution or portion of any institution that is primarily for rest, the aged, nonskilled care, or care of mental diseases or substance abuse. Room and board services are not covered when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services include semi-private room (private room provided when medically necessary), drugs, specialty pharmaceuticals, medical social services, short term physical, speech, occupational therapies (subject to limits) and other services generally provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Autism Spectrum Disorder Services

Source:
Secretary-Approved Other

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
60 combined visits annually.

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 60 combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.

Benefit, formerly known as Pervasive Development Disorder (PDD), is a state mandate that must be covered as outlined in the Indiana insurance code.

Benefit provides coverage for Asperger's syndrome and autism. Coverage for services are provided as prescribed by the treating physician in accordance with the treatment plan.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Hearing Aids

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1 per member every 5 years.

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medically frail populations will receive State Plan benefits.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Home Health:Medical Supplies, Equipment and Applia

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include non-durable supplies and/or convenience items.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include medical supplies in connection with home health care.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Benefit Provided:
Inpatient Cardiac Rehabilitation

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
90 days annual maximum.

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes services for the improvement of cardiac disease or dysfunction.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Inpatient Rehabilitation Therapy

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
90 days annual maximum

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

Rehabilitative and habilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes physical, occupational, speech and pulmonary therapy of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

■ 8. Essential Health Benefit: Laboratory services — Collapse All ☐

Benefit Provided: Lab Tests
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Coverage does not include lab expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: X-Rays
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Coverage does not include x-ray expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Imaging- MRI, CT, and PET
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary. Coverage also includes MRA and SPECT scan.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Pathology

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Radiology

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: EKG and EEG

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided: Preventive Care Services

Source: Base Benchmark Commercial HMO

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician services for wellness and preventive services include but are not limited to routine physical exam, routine total blood cholesterol screening, routine gynecological services and routine immunizations. Includes (1) all preventive items or services that have a rating of 'A' or 'B' by the United States Preventive Task Force (USPSTF); (2) Immunizations recommended for the individuals age and health status by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); (3) for infants, children, adolescents and adults, preventive care and screenings included in the Health Resources and Services Administration's (HRSA) Bright Futures comprehensive guidelines; and (4) preventive screenings for women as recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided: Diabetes Self Management Training

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services are limited to physician authorized visits after receiving a diagnosis of diabetes; after receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management; and for re-education or refresher training.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided: Health Education

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 3 visits

Duration Limit: None

Scope Limit:

Classes in nutrition or smoking cessation will be approved up to 3 visits when referred by your physician

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided by the PCP as part of preventive health care and other health education classes approved by the insurer.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Routine Prostate Specific Antigen (PSA) Test

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

One test annually for an individual who is at least 50 years old or less than 50 if at high risk for prostate cancer.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

None

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Remove

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
EPSDT is required in the ABP for 19 and 20 year olds.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided under EPSDT may include preventive and diagnostic services that are medically necessary and may need continued treatment.

In accordance with CMS regulation, individuals covered under EPSDT are not subject to the IMD exclusion

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☒

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Infertility Diagnoses: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Infertility Diagnoses benefit offered in the base benchmark was removed and replaced in EHB 1 by substitution with part of the actuarial value of Male Sterilization procedures which are not covered on the base benchmark. Coverage for voluntary Male Sterilization procedures comes from the coverage provided on the State Plan.

Base Benchmark Benefit that was Substituted: Routine Foot Care: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. A more restrictive limit of 6 visits per year was added. In EHB 1, this has been substituted with the remaining actuarial value from the male sterilization benefit. There is no limit on Routine Foot Care in the base benchmark.

Base Benchmark Benefit that was Substituted: Home Health Services: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, training of family members to provide home health services is a non-covered benefit. In EHB 1, this sub-benefit was substituted with the actuarial value remaining from the male sterilization benefit.

Base Benchmark Benefit that was Substituted: Urgent Care-Walkins: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, physician home visits is a non-covered benefit. In EHB 1, this sub-benefit was substituted with the actuarial value remaining from the male sterilization benefit.

Base Benchmark Benefit that was Substituted: Maternity Services: duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was duplicated with the Medicaid State Plan Obstetric benefit in EHB 4.

Base Benchmark Benefit that was Substituted: Maternity - Delivery: duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was duplicated with the Medicaid State Plan Obstetric benefit in EHB 4.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment (DME): substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. The limits for a 15 month rental cap and 5 year replacement for equipment were added. In EHB 7, this has been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. There is no limit on Durable Medical Equipment in the base benchmark.

Base Benchmark Benefit that was Substituted: PT, OT, ST: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 60 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted: Cardiac Rehabilitation: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 60 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted: Pulmonary Rehabilitation: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with hearing aids. In addition, formalized and pre-designed rehabilitation programs for pulmonary conditions have also been substituted with hearing aids. Both substitutions were completed with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 60 combined visits per distinct condition or episode.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Autism Spectrum Disorder Services: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 60 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted: Applied Behavior Analysis: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

In EHB 7, ABA has been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan.

Base Benchmark Benefit that was Substituted: Non-Surgical Treatment Option Morbid Obesity: dupl

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

In EHB 9, the benefit is covered under preventive and wellness services. The ACA preventive services provides coverage above the benefit limits.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Adult Vision
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Adult vision is covered in the base benchmark plan, but it is an excepted benefit and therefore not an Essential Health Benefit.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Newborn Child Coverage
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Benefit is excluded since the ABP is for ages 19-64. Newborns born to members will be covered through Medicaid for children. The newborn coverage includes the initial newborn examinations.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Emergency Services Outside the U.S.
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Emergency care provided outside the U.S. is covered in the base benchmark plan. Non-emergency services are not covered. To conform with Medicaid standards, the benefit will not be covered in the ABP.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Lodging and Transportation for Transplants (Donor)
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Transportation and lodging services for the donor are covered under the base benchmark plan subject to a dollar limit, these services are not considered an EHB and are considered a non-covered benefit for the ABP.

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided: Chiropractic Care - Pregnancy Benefit

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Limits equivalent to State Plan

Duration Limit: None

Scope Limit: None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided: Non-emergency Transportation - Pregnancy Benefit

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Other 1937 Benefit Provided: Medicaid Rehabilitation Option (MRO)- Pregnancy Be

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. MRO services are designed to assist in the rehabilitation of the consumer‘s optimum functional ability in daily living activities.

Other 1937 Benefit Provided:
Dental Services - Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits equivalent to State Plan

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The dental benefits include State Plan equivalent benefits.

For authorization, the dental insurer may require prior authorization requirements, such as general member information and a justification for the type of dental services rendered based on the medical needs of the member

Other 1937 Benefit Provided:
TMJ - Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage includes treatment of temporomandibular joint (TMJ) disorder.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, documentation of non-surgical treatment and duration prior to surgery and a justification of services rendered for the medical needs and circumstances of the member.

Other 1937 Benefit Provided: Adult Vision - Pregnancy Benefit

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Limits equivalent to the State Plan

Duration Limit: None

Scope Limit: None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The benefits include State Plan equivalent benefits.

For authorization, the vision insurer may require prior authorization requirements, such as general member information and a justification for the type of vision services rendered based on the medical needs of the member.

Other 1937 Benefit Provided: Health Education - Smoking Cess -Pregnancy Benefit

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 12 week course

Duration Limit: None

Scope Limit: None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The benefit includes up to 12 weeks in a smoking cessation course providing treatment and counseling.
For authorization, the Managed Care Entity (MCE) may require prior authorization requirements, such as general member information and a justification for the type of services rendered based on the medical needs of the member.

Other 1937 Benefit Provided:
Osteopathic Manipulative Treatment (OMT)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
State Plan benefit.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided:
Residential Treatment

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:

Duration Limit:

Scope Limit:
Statewide average length of stay of 30 calendar days, based on medical necessity.

Other:
Services provided to individuals in IMDs with an SUD diagnosis when determined medically necessary by the MCO utilization review staff and in accordance with an individualized service plan.

Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a).

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided:
Qualifying Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Confirming coverage of routine patient costs in qualifying clinical trials as required under Section 1905(a)(30) and 1905(gg) of the Social Security Act. Coverage is provided as defined in the State Plan Attachment 3.1-A under item 30.

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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