Centers for Medicare & Medicaid Services, HHS  

§ 440.330  

(j) The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(i)(XVIII) and 1902(aa) of the Act.  


(l) The individual is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.  

(m) The individual is determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.  

[75 FR 23101, April 30, 2010, as amended at 78 FR 42306, July 15, 2013]  

§ 440.320 State plan requirements: Optional enrollment for exempt individuals.  

(a) General rule. A State plan that offers exempt individuals as defined in §440.315 the option to enroll in benchmark or benchmark-equivalent coverage must identify in its State plan the exempt groups for which this coverage is available, and must comply with the following provisions:  

(1) In any case in which the State offers an exempt individual the option to obtain coverage in a benchmark or benchmark-equivalent benefit package, the State must effectively inform the individual prior to enrollment that the enrollment is voluntary and that the individual may disenroll from the benchmark or benchmark-equivalent coverage at any time and regain immediate access to standard full Medicaid coverage under the State plan.  

(2) Prior to any enrollment in benchmark or benchmark-equivalent coverage, the State must inform the exempt individual of the benefits available under the benchmark or benchmark-equivalent benefit package and the costs under such a package and provide a comparison of how they differ from the benefits and costs available under the standard full Medicaid program. The State must also inform exempt individuals that they may disenroll at any time and provide them with information about the process for disenrolling.  

(3) The State must document in the exempt individual’s eligibility file that the individual was informed in accordance with this section prior to enrollment, was given ample time to arrive at an informed choice, and voluntarily and affirmatively chose to enroll in the benchmark or benchmark-equivalent benefit package.  

(4) For individuals who the State determines have become exempt individuals while enrolled in benchmark or benchmark-equivalent coverage, the State must comply with the requirements in paragraphs (a)(1) through (a)(3) of this section above within 30 days after such determination.  

(b) Disenrollment Process. (1) The State must act upon requests promptly for exempt individuals who choose to disenroll from benchmark or benchmark-equivalent coverage.  

(2) The State must have a process in place to ensure that exempt individuals have access to all standard State plan services while disenrollment requests are being processed.  

(3) The State must maintain data that tracks the total number of beneficiaries that have voluntarily enrolled in a benchmark plan and the total number of individuals that have disenrolled from the benchmark plan.  

§ 440.325 State plan requirements: Coverage and benefits.  

Subject to requirements in §§440.345 and 440.365, States may elect to provide any of the following types of health benefits coverage:  

(a) Benchmark coverage in accordance with §440.330.  

(b) Benchmark-equivalent coverage in accordance with §440.335.  

§ 440.330 Benchmark health benefits coverage.  

Benchmark coverage is health benefits coverage that is equal to the coverage under one or more of the following benefit plans:  

(a) Federal Employees Health Benefit Plan Equivalent Coverage (FEHBP—Equivalent Health Insurance Coverage). A benefit plan equivalent to the standard Blue Cross/Blue Shield preferred provider option service benefit plan...