(j) The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(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 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
§ 440.335 Benchmark-equivalent health benefits coverage.

(a) Aggregate actuarial value. Benchmark-equivalent coverage is health benefits coverage that has an aggregate actuarial value, as determined under §440.340, that is at least actuarially equivalent to the coverage under one of the benchmark benefit packages described in §440.330 for the identified Medicaid population to which it will be offered.

(b) Required coverage. Benchmark-equivalent health benefits coverage must include coverage for the following categories of services:

1. Inpatient and outpatient hospital services.
2. Physicians' surgical and medical services.
3. Laboratory and x-ray services.
4. Well-baby and well-child care, including age-appropriate immunizations.
5. Emergency services.
6. Family planning services and supplies and other appropriate preventive services, as designated by the Secretary.
7. Prescription drugs.
8. Mental health benefits.

(c) Additional coverage. In addition to the types of benefits of this section, benchmark-equivalent coverage may include coverage for any additional benefits of the type which are covered in 1 or more of the standard benchmark coverage packages described in §440.330 or State plan benefits, described in section 1905(a), 1915(i), 1915(j), 1915(k) and 1945 of the Act, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in 45 CFR 156.100.

1. States wishing to elect Secretary-approved coverage should submit a full description of the proposed coverage (including a benefit-by-benefit comparison of the proposed plan to one or more of the three other benchmark plans specified above or to the State's standard full Medicaid coverage package), and of the population to which coverage will be offered. In addition, the State should submit any other information that will be relevant to a determination that the proposed health benefits coverage will be appropriate for the proposed population.

2. [Reserved]

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