See Section 2.D of Attachment

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.

Covered services, including new benefits adding prevention services, adult physicals, and prevention and health assistance benefits are identified in Section 3.

c. _X_ / Geographical Classification

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

List any geographic variations:

See Section 1.C of Attachment

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

B. Description of the Benefits

_X_ / The State will provide the following alternative benefit packages (check all that apply). *Basic Plan*

1937(b) 1. _X_ / 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 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.

Covered services, including new benefits adding prevention services, adult physicals, and prevention and health assistance benefits are identified in Section 3.

2. ___/ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan:_____.

a. ___/ 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

by the US Prevention Services Task Force Guide to Clinical Preventive Services. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services".

3.G.4 Screening Services

Mammography Services. The Basic Benchmark Benefit Package screening mammographies performed with certified mammography equipment and staff. Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age.

Diagnostic Screening Clinics. The Basic Benchmark Benefit Package includes services provided in a diagnostic screening clinic are outlined in applicable Department rules.

Limitations. Service limitations are as follows: five (5) hours of medical social services per eligible recipient per state fiscal year is the maximum allowable. Limit of no more than five (5) hours of medical social services per recipient in each state fiscal year will be waived for EPSDT recipients.

3.G.5 Prevention and Health Assistance Benefits

The Basic Benchmark Benefit Package includes certain enhanced Prevention and Health Assistance (PHA) benefits for targeted individuals provided in accordance with applicable Department rules.

Personal Health Accounts. A personal health account is an individualized account established for enhanced PHA benefits. Account transactions will be managed through a gatekeeper within the state Medicaid agency.

Personal Health Accounts made available under the Basic Benchmark Benefit Package will be targeted to individuals who:

- Use tobacco, or
- are obese.

Vouchers will be generated to individuals who have earned credits and may be used to purchase goods and services related to tobacco cessation and weight reduction/management in accordance with applicable Department rules. These goods and services may include nicotine patches or gum, approved fitness program memberships, weight-loss program memberships and

bicycle helmets.

Credits in a personal health account may also be increased by complying with recommended preventive care including on-time immunizations and well-child checks. These credits may be used by those participants subject to premiums for payment of premiums.

3.G.6 Nutrition Services

The Basic Benchmark Benefit Package includes intensive nutritional education, counseling, and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetics Association to assure the patient's proper nutrition is allowed. Payment is made at a rate established in accordance with applicable Department rules. Nutrition services must be discovered by the screening services and ordered by the physician; must be medically necessary; and, if over two (2) visits per year are needed, must be authorized by the Department prior to the delivery of additional visits.

Limitations. Nutrition services related to obesity, including dietary assessment and individualized nutrition education, shall not be subject to the above limitations when provided as PHA benefits.

The Basic Benchmark Benefit Package includes Diabetes Education and Training Clinics which provide diabetic education and training services are outlined in applicable Department rules. Outpatient diabetes education and training services will be covered under the following conditions.

The education and training services are provided through a diabetic management program recognized as meeting the program standards of the American Diabetes Association.

The education and training services are provided through a formal program conducted through a hospital outpatient department or a physician's office by a Certified Diabetic Educator certified by the American Diabetes Association.

Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will