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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: 25-0030

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Form CMS 179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

February 6, 2026

Krista Fremming
Interim Director
Medical Services Division
North Dakota Department of Health and Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505

Re: North Dakota State Plan Amendment (SPA) – 25-0030

Dear Director Fremming:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0030. This amendment proposes to amend the Alternative Benefit State Plan to include coverage for Community Health Worker and Community Paramedic Services.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR 447 Part C. This letter informs you that North Dakota's Medicaid SPA TN 25-0030 was approved on February 5, 2026, with an effective date of October 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the North Dakota State Plan.

If you have any questions, please contact Tyson Christensen at (816) 426-6440 or via email at Tyson.Christensen@cms.hhs.gov.

Sincerely,

Wendy E. Hill Petras
Acting Director, Division of Program Operations

Enclosures

cc: LeeAnn Thiel

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Part C

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

~~A ABP5, B ABP5~~

*Attachment 3.1-L, Medicaid Expansion 19-20, ABP 5

*Attachment 3.1-L, Medicaid Expansion 21-64, ABP 5

1. TRANSMITTAL NUMBER

2 5 — 0 0 3 0

2. STATE

ND

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL
SECURITY ACT

XIX

XXI

4. PROPOSED EFFECTIVE DATE

October 1, 2025

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2025 \$ 0
b. FFY 2026 \$ 0

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)

~~A ABP5, B ABP5~~

*Attachment 3.1-L, Medicaid Expansion 19-20, ABP 5 (TN: 25-0014)

*Attachment 3.1-L, Medicaid Expansion 21-64, ABP 5 (TN: 25-0017)

9. SUBJECT OF AMENDMENT

Amends the Alternative Benefit State Plan to provide coverage for Community Health Worker and Community Paramedic Services

10. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

Sarah Aker, Director
Medical Services Division

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Sarah Aker

13. TITLE
Medical Services Director

14. DATE SUBMITTED
November 13, 2025

15. RETURN TO

Sarah Aker, Director
Medical Services Division
ND Department of Health and Human Services
600 East Boulevard Avenue Dept 325
Bismarck ND 58505-0250

FOR CMS USE ONLY

16. DATE RECEIVED

November 13, 2025

17. DATE APPROVED

February 5, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

October 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

Wendy E. Hill Petras

21. TITLE OF APPROVING OFFICIAL

Acting Director, Division of Program Operations

22. REMARKS

*Pen and Ink change approved by state on February 4, 2026



Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ND - 25 - 0030

Benefits Description

ABP5

The state/territory proposes a “Benchmark-Equivalent” benefit package.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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

Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:

Outpatient Hospital Surgical Center

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Exclusions include: surgical procedures that can be done in Practitioner's office (i.e. vasectomy, toe nail removal) and complications from a non-covered procedure or service.

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

Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a

Benefit Provided:

Primary Care to Treat Illness/Injury

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 5.a; Attachment 3.1-B section 5.a

Benefit Provided:

Specialty Visits

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Alternative Benefit Plan

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

Attachment 3.1-A section 5.a; Attachment 3.1-B section 5.a

Benefit Provided:

Chiropractic

Source:

State Plan 1905(a)

[Remove](#)

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20 visits per calendar year

Duration Limit:

None

Scope Limit:

Exclusion: Joint manipulation outside of the spine is not covered.

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

Attachment 3.1-A section 6.c; Attachment 3.1-B section 6.c

Includes 2 x-rays per year.

Additional visits allowed with prior authorization.

Benefit Provided:

Chemotherapy Services

Source:

State Plan 1905(a)

[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:

Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a

Benefit Provided:

Radiation Therapy

Source:

State Plan 1905(a)

[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:

Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a

[Remove](#)

Benefit Provided:

Anesthesia

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a

[Remove](#)

Benefit Provided:

Home Health Care Non Rehab

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

50 visits per member per calendar year

Duration Limit:

None

Scope Limit:

Exclusions: Eye drops or ointment instillations, Routine glucose monitoring and insulin administration, Routine foot care, Stasis ulcer maintenance care, Pediatric maintenance care, Routine medication setup,

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

Attachment 3.1-A section 7; Attachment 3.1-B section 7

Exclusions continued: Other services that become self-care activities after the member or family members or others have been taught how to do the procedure(s) in a reasonable amount of time, Light housekeeping, Transportation, Meal preparation, Laundry, Shopping, Childcare and Respite care.

Additional visits allowed with prior authorization which are valid for 60 days.

Alternative Benefit Plan

Benefit Provided:

Dialysis

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a

Benefit Provided:

Other Licensed Practitioner - OLP

Source:

State Plan 1905(a)

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:

Attachment 3.1-A Item 6.d and Attachment 3.1-B Item 6.d

- Psychologists
- Certified Registered Nurse Anesthetist
- Nurse Practitioners who meet North Dakota's advanced educational and clinic practice requirements and who are certified in specialties in addition to family and pediatric nurse practitioner services.
- Clinical Social worker
- Registered Pharmacist
- Physician Assistants and Clinical Nurse Specialists
- Marriage and Family Therapists and Licensed Professional Clinical Counselors
- Professional Counselor

Add



Alternative Benefit Plan

2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided:

Emergency Room Facility/Professional

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a

Benefit Provided:

Ambulance Transportation

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

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:

Attachment 3.1-D

Benefit Provided:

Urgent Care Services

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Exclusion: ND Medicaid does not cover any services received outside of the United States.



Alternative Benefit Plan

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

Attachment 3.1-A section 9; Attachment 3.1-B section 9

Add

Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:	Source:	<input type="button" value="Remove"/>
Inpatient Medical and Surgical Care	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	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:		
Attachment 3.1-A section 1; Attachment 3.1-B section 1		
Exclusions: Admission Kits, Ambulance Charges, Patient Convenience Items, Barber/Beauty, Postage, Biofeedback, Private Room, Books/Tapes, Social Services, Guest Tray, Take Home Drugs, Late Discharge, Take Home Supplies, Leave of Absence Room, Tax, Lif		

Benefit Provided:	Source:	<input type="button" value="Remove"/>
Bariatric Surgery	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Limit 1 per lifetime	None	
Scope Limit:		
Medical necessity must be met.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Attachment 3.1-A section 1 and section 5.a; Attachment 3.1-B section 1 and section 5.a Limits can be exceeded if prior authorized and determined medically necessary by the state.		

Benefit Provided:	Source:	<input type="button" value="Remove"/>
Transplants	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Procedure must be medically necessary and not specified as experimental.		

Alternative Benefit Plan

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

Attachment 3.1-E

Benefit Provided:

Anesthesia

Source:

State Plan 1905(a)

[Remove](#)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage of services when personally furnished by an anesthesiologist or CRNA

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

Attachment 3.1-A section 1; Attachment 3.1-B section 1

Benefit Provided:

Hospice

Source:

State Plan 1905(a)

[Remove](#)

Authorization:

Prior Authorization

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:

Attachment 3.1-A section 18; Attachment 3.1-B section 18

A member must be certified as terminally ill to be eligible for coverage of hospice care. Hospice care may continue until a member is no longer certified as terminally ill or until the member or representative revokes the election of hospice.

Benefit Provided:

Reconstructive Surgery

Source:

State Plan 1905(a)

[Remove](#)

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Surgery to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

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

Attachment 3.1-A section 1; Attachment 3.1-B section 1

Add



Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:

Delivery and Maternity Services

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 1, section 3, section 5, section 6.d, section 17, section 20;
Attachment 3.1-B section 1, section 3, section 5, section 6.d, section 17, section 20

Benefit Provided:

Pre and Postnatal Care

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 3, section 5, section 6.d, section 17, section 20;
Attachment 3.1-B section 3, section 5, section 6.d, section 17, section 20

Alternative Benefit Plan

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

Collapse All

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.

Benefit Provided:	Source:	<input type="button" value="Remove"/>
Mental Health Inpatient Treatment	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	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:		
Attachment 3.1-A section 1; Attachment 3.1-B section 1		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
Substance Use Disorder Inpatient Treatment	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	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:		
Attachment 3.1-A section 1; Attachment 3.1-B section 1		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
Mental Health Outpatient Treatment	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	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:

Attachment 3.1-A section 13d; Attachment 3.1-B section 13d

[Remove](#)

Benefit Provided:

Substance Abuse Disorder Outpatient Treatment

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 13d; Attachment 3.1-B section 13d

[Add](#)



Alternative Benefit Plan

■ 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.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

No

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

The state's ABP prescription drug benefit is the same as the approved Medicaid state plan for prescribed drugs.

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.

Benefit Provided:

Outpatient Rehabilitation Services

Source:

State Plan 1905(a)

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:

Reference approved State Plan, Attachment 3.1-A, section 2.a

Includes PT, OT and ST

Benefit Provided:

Cardiac Rehab

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to Plan Guidelines

Duration Limit:

None

Scope Limit:

Coverage up to 36 sessions consisting typically of three sessions per week in a single 12-week period.

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

Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a

Limits can be exceeded if prior authorized and determined medically necessary by the state.

Benefit Provided:

Durable Medical Equipment

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to Plan Guidelines

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

Prior authorization and/or limitations may apply to certain items per the Plan guidelines

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

Attachment 3.1-A section 7.c; Attachment 3.1-B section 7.c

Limits can be exceeded if prior authorized and determined medically necessary by the state.

[Remove](#)

Benefit Provided:

Prosthetics and Orthotics

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to Plan Guidelines

Duration Limit:

None

Scope Limit:

Prior authorization and/or limitations may apply to certain items per the Plan guidelines

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

Attachment 3.1-A section 12.c; Attachment 3.1-B section 12.c

Limits can be exceeded if prior authorized and determined medically necessary by the state.

[Remove](#)

Benefit Provided:

Home Health Services

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

50 visits per member per calendar year

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:

Attachment 3.1-A section 7; Attachment 3.1-B section 7

Limits can be exceeded if prior authorized and determined medically necessary by the state.

[Remove](#)

Benefit Provided:

Habilitation Services

Source:

State Plan 1905(a)

Authorization:

None

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:

Reference approved State Plan, Attachment 3.1-A, section 2.a
Includes PT, OT and ST

Add



Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:

LAB, RADIOLOGY AND DIAGNOSTIC SERVICES

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 2.a and section 3; Attachment 3.1-B section 2.a and section 3

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).

Benefit Provided:

Preventative Care/Screening/Immunizations

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 4.b and section 5.a; Attachment 3.1-B section 4.b and section 5.a

Benefit Provided:

Medical Nutritional Therapy

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

4 hours per calendar year

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:

Attachment 3.1-A section 13.c

Limits can be exceeded if prior authorized and determined medically necessary by the state.

Benefit Provided:

Tobacco Cessation Counseling Services

Source:

State Plan 1905(a)

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:

Attachment 3.1-A ; Attachment 3.1-B

[Remove](#)

Benefit Provided:

Allergy Services

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Does not cover the administration of oral preparations used to treat food allergies (e.g., food drops, etc.) or other allergy services not recognized as a medical standard for the provision of allergy immunotherapy.

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

Attachment 3.1-A section 5.a and section 6.d; Attachment 3.1-B section 5.a and section 6.d

[Remove](#)

Benefit Provided:

Family Planning

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Noncovered Services: Reversal of elective sterilization, Hysterectomies for the purpose of sterilization.

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

Attachment 3.1-A section 4.c; Attachment 3.1-B section 4.c

[Remove](#)

Benefit Provided:

Diabetes Equipment, Supplies, Education

Source:

State Plan 1905(a)



Alternative Benefit Plan

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:

Attachment 3.1-A section 6.d; Attachment 3.1-B section 6.d

[Remove](#)

Benefit Provided:

Wellness Services

Source:

State Plan 1905(a)

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:

Attachment 3.1-A section 4.b and section 5.a; Attachment 3.1-B section 4.b and section 5.a

[Add](#)



Alternative Benefit Plan

<input checked="" type="checkbox"/> 10. Essential Health Benefit: Pediatric services including oral and vision care	<input type="checkbox"/> Collapse All																		
<table border="1"><tr><td>Benefit Provided: Medicaid State Plan EPSDT Benefits</td><td>Source: State Plan 1905(a)</td><td><input type="button" value="Remove"/></td></tr><tr><td>Authorization: None</td><td>Provider Qualifications: Medicaid State Plan</td><td></td></tr><tr><td>Amount Limit: None</td><td>Duration Limit: None</td><td></td></tr><tr><td>Scope Limit: None</td><td></td><td></td></tr><tr><td colspan="3">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b</td></tr><tr><td colspan="3"><input type="button" value="Add"/></td></tr></table>		Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	<input type="button" value="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: Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b			<input type="button" value="Add"/>		
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	<input type="button" value="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: Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b																			
<input type="button" value="Add"/>																			



Alternative Benefit Plan

11. Other Covered Benefits from Base Benchmark

[Collapse All](#)



Alternative Benefit Plan

<input checked="" type="checkbox"/> 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication	Collapse All <input type="checkbox"/>	
Base Benchmark Benefit that was Substituted: Primary Care Visit to Treat Injury/Illness - Dup	Source: Base Benchmark	<input type="button" value="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: Primary care visits to treat injury or illness are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5; Attachment 3.1-B, section 5.a and are within EHB 1, ambulatory patient services.		
Base Benchmark Benefit that was Substituted: Specialty Visits - Duplication	Source: Base Benchmark	<input type="button" value="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: Specialty visits to treat injury or illness are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5; Attachment 3.1-B, section 5.a and are within EHB 1, ambulatory patient services.		
Base Benchmark Benefit that was Substituted: Other Practitioner Office Visits - Duplication	Source: Base Benchmark	<input type="button" value="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: Other practitioner office visits are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and are within EHB 1, ambulatory patient services.		
Base Benchmark Benefit that was Substituted: Outpatient Facility (Ambulatory Surg Ctr) - Dup	Source: Base Benchmark	<input type="button" value="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: Outpatient facility fee (e.g., ambulatory surgery center) services are a base benchmark benefit covered under the State Plan Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a and are within EHB 1, ambulatory patient services.		
Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical - Dup	Source: Base Benchmark	<input type="button" value="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: Outpatient surgery physician/surgical services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a and are within EHB 1, ambulatory patient services.		



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Hospice 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:

Hospice services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 18; Attachment 3.1-B section 18 and are within EHB 3, hospitalization.

A member must be certified as terminally ill to be eligible for coverage of hospice care. Hospice care may continue until a member is no longer certified as terminally ill or until the member or representative revokes the election of hospice.

Base Benchmark Benefit that was Substituted:

Urgent Care Centers - 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:

Urgent Care services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 9; Attachment 3.1-B section 9 and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted:

Home Health Care 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:

Home Health Care services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 7; Attachment 3.1-B section 7 and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted:

Emergency Room 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:

Emergency room services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted:

Emergency Transportation/Ambulance - 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:

Emergency Transportation/Ambulance services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a and are within EHB 2, emergency services.



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Inpatient Hospital 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:

Inpatient hospital services (inpatient stay) are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 1; Attachment 3.1-B section 1 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted:

Inpatient Physician and Surgical Services - Dup

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:

Inpatient physician & surgical services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 1; Attachment 3.1-B section 1 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted:

Bariatric Surgery - 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:

Bariatric services are a base benchmark benefit covered under the State Plan, Attachment 3.1-B section 1 and section 5.a and are within EHB 3, Hospitalization.

Base Benchmark Benefit that was Substituted:

Skilled Nursing Facility - 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:

Skilled Nursing Facility services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 24.d and are within EHB 7, Rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Prenatal and Postnatal Care - 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:

Prenatal and Postnatal Care services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 1, section 3, section 5, section 6.d, section 17, section 20; Attachment 3.1-B section 1, section 3, section 5, section 6.d, section 17, section 20 and are within EHB 4, Maternity and newborn care.

Base Benchmark Benefit that was Substituted:

Delivery & Inpatient Services for Maternity - Dup

Source:

Base Benchmark

[Remove](#)



Alternative Benefit Plan

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:

Prenatal and Postnatal Care services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 1, section 3, section 5, section 6.d, section 17, section 20; Attachment 3.1-B section 1, section 3, section 5, section 6.d, section 17, section 20 and are within EHB 4, Maternity and newborn care.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Outpatient Services - Dup

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:

Mental/Behavioral Health Outpatient Services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 13d; Attachment 3.1-B section 13d and are within EHB 5, Mental health and substance use disorder services.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Inpatient Services - Dup

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:

Mental/Behavioral Health Outpatient Services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 1; Attachment 3.1-B section 1 and are within EHB 5, Mental health and substance use disorder services.

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Outpatient Services - Dup

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:

Mental/Behavioral Health Outpatient Services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 13d; Attachment 3.1-B section 13d and are within EHB 5, Mental health and substance use disorder services.

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Inpatient Services - Dup

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:

Mental/Behavioral Health Outpatient Services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 1; Attachment 3.1-B section 1 and are within EHB 5, Mental health and substance use disorder services.

Base Benchmark Benefit that was Substituted:

Outpatient Rehabilitation Services - Dup

Source:

Base Benchmark

Remove



Alternative Benefit Plan

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:

Outpatient rehabilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Chiropractic Care - 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:

Chiropractic services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 6.c; Attachment 3.1-B section 6.c and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment - 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:

Durable Medical Equipment services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 7.c; Attachment 3.1-B section 7.c and are within EHB 7, Rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Imaging (CT/PET Scans, MRIs) - 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:

Imaging services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a and section 3; Attachment 3.1-B section 2.a and section 3 and are within EHB 8, Laboratory services.

Base Benchmark Benefit that was Substituted:

Preventive Care/Screening/Immunization - Dup

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:

Preventative care/screening/immunization services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 4.b and section 5.a; Attachment 3.1-B section 4.b and section 5.a and are within EHB 9, Preventive and wellness service and chronic disease management.

Base Benchmark Benefit that was Substituted:

Routine Eye Exam for Children - 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:

Routine Eye Exam for Children are a base benchmark benefit covered under the State Plan, Attachment



Alternative Benefit Plan

3.1-A section 4.b; Attachment 3.1-B section 4.b and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Eye Glasses for Children - 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:

Routine Eye Exam for Children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Dental Check-Up for Children - 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:

Dental Check-up for Children is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Habilitation Servics - 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:

Habilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Well Baby Visits and Care - 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:

Well baby visits and care are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Lab Outpatient and Professional Services - Dup

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:

Imaging (CT/PET Scans, MRIs) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a and section 3; Attachment 3.1-B section 2.a and section 3 and are within EHB 8, laboratory services.



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

X-rays and Diagnostic Imaging - 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:

Imaging (CT/PET Scans, MRIs) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a and section 3; Attachment 3.1-B section 2.a and section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted:

Basic Dental Care - Child - 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:

Basic Dental Care are a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Orthodontia - Child - 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:

Orthodontia care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Major Dental Care - Child - 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:

Major Dental care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Transplant - 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:

Transplant services are a base benchmark benefit covered under the State Plan, Attachment 3.1- E and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted:

Accidental Dental - Duplication

Source:

Base Benchmark

[Remove](#)

Alternative Benefit Plan

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:

Accidental Dental care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Dialysis - 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:

Dialysis is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:

Allergy Testing - 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:

Allergy testing is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 5.a and section 6.d; Attachment 3.1-B section 5.a and section 6.d and is within EHB 9, Preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted:

Chemotherapy - 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:

Chemotherapy is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:

Radiation - 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:

Radiation is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2.a; Attachment 3.1-B section 2.a and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:

Diabetes Education - 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:

Diabetes education is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 13.c. and is within EHB 9, preventive and wellness services and chronic disease management.



Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Prosthetic Devices - 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:

Prosthetic devices is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 12.c; Attachment 3.1-B section 12.c and is within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Infusion Therapy - 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:

Infusion therapy is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 2 and section 5.a EHB 1, Ambulatory patient services.

Base Benchmark Benefit that was Substituted:

Treatment for TMJ - 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:

Treatment for TMJ is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 4.b; Attachment 3.1-B section 4.b and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:

Nutritional Counseling - 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:

Nutritional Counseling is a base benchmark benefit covered under Medical Nutritional Therapy under the State Plan, Attachment 3.1-A section 13.c. and is within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted:

Reconstructive Surgery - 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:

Reconstructive surgery is a base benchmark benefit covered under the State Plan, Attachment 3.1-A section 1; Attachment 3.1-B section 1 and is within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted:

Rehabilitation Speech Therapy - Duplication

Source:

Base Benchmark

[Remove](#)



Alternative Benefit Plan

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:

Rehabilitation speech therapy services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachments 3.1-A section 13 and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:

Rehab Occupational & Physical Therap - 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:

Rehabilitation occupational and physical services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachments 3.1-A section 13 and are within EHB 7, rehabilitative and habilitative services and devices.

Add



Alternative Benefit Plan

13. Other Base Benchmark Benefits Not Covered

[Collapse All](#)

Alternative Benefit Plan

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

Non-emergency transportation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 24a.

Reference approved State Plan, Attachment 3.1-D.

Other 1937 Benefit Provided:

Podiatric services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 6.a.

Other 1937 Benefit Provided:

Optometrist Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 per year

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 6.b

Transmittal Number: ND-25-0030 Approval Date: February 5, 2026

Effective Date: October 1, 2025

Supersedes Transmittal Number: ND-25-0014



Alternative Benefit Plan

Limit can be exceed if medically necessary.

Other 1937 Benefit Provided:

Personal Care Services

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:

Reference approved State Plan, Attachment 3.1-A, section 26.

Other 1937 Benefit Provided:

Medication Therapy Mgmt Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Maximum of 4 MTM encounters per 365 days.

Other:

Reference approved State Plan, Attachment 3.1-A, section 13.C

Limit can be exceed if medically necessary.

Other 1937 Benefit Provided:

ICF/IID services

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



Alternative Benefit Plan

Other:

Reference approved State Plan Section 3.1-A, section 15.

Remove

Other 1937 Benefit Provided:

Routine Patient Cost in Qualifying Clinical Trials

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 30.

Remove

Other 1937 Benefit Provided:

Targeted Case Management

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 19

4 Types: Ind with Behavioral Health Condition, Ind in CW system, High Risk Pregnant Women and Eligible Juveniles

Remove

Other 1937 Benefit Provided:

Medication Assisted Treatment Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, Supplement 8
Revised within TN 20-0026 effective 10/01/2020.

MAT is provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.

Other 1937 Benefit Provided:

Nursing Facility - Long Term Care

[Remove](#)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 24.d

Other 1937 Benefit Provided:

1915(i) Behavioral Health HCBS

[Remove](#)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Attachment 3.1-i

Services must be determined medically necessary by the state.

The service are limited to individuals with a behavioral health diagnosis along with a completed WHODAS assessment reviewed and approved by the state.

Other 1937 Benefit Provided:

Other Licensed Practitioners - OLP

Transmittal Number: ND-25-0030

Approval Date: February 5, 2026

Effective Date: October 1, 2025

Supersedes Transmittal Number: ND-25-0014

Alternative Benefit Plan

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:

Attachment 3.1-A Item 6.d and Attachment 3.1-B Item 6.d

- Licensed Registered Nurse
- Licensed School Psychologist

Other 1937 Benefit Provided:

Community Health Worker (CHW)

[Remove](#)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

100 Units

Duration Limit:

None

Scope Limit:

None

Other:

Attachment 3.1-A Item 13.c and Attachment 3.1-B Item 13.c

Services Covered:

- Health System Navigation and Resource Coordination
- Health Promotion and Coaching
- Health Education and Training

Additional visits allowed with prior authorization

Other 1937 Benefit Provided:

Comm Paramedics and Emergency Medical Tech

[Remove](#)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

50 visits in a year

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

Services must be referred by a physician or Other Licensed Practitioner within their scope of practice according to state law.

Other:

Attachment 3.1-A Item 13.c and Attachment 3.1-B Item 13.c

Services Covered:

- In-home assessments and chronic disease monitoring
- Post-hospital discharge follow-ups
- Medication compliance checks
- Referrals to social and mental health services
- Preventive care and health education

Additional visits allowed with prior authorization

Add



Alternative Benefit Plan

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.

V.20190808



Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ND - 25 - 0030

Benefits Description

ABP5

The state/territory proposes a “Benchmark-Equivalent” benefit package.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

BlueCare Gold 90 500

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

Secretary-Approved Coverage with benefits and limitations source from a combination of the North Dakota's EHB Benchmark Plan and the North Dakota Medicaid State Plan.

Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:

Outpatient Hospital Surgical Center

Source:

Base Benchmark Commercial HMO

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Exclusions include: surgical procedures that can be done in Practitioner's office (i.e. vasectomy, toe nail removal) and complications from a non-covered procedure or service.

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

Benefit Provided:

Primary Care to Treat Illness/Injury

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Exclusions Include: Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management; and complications from a non-covered procedure or service.

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

Benefit Provided:

Special Visits

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Transmittal Number: ND-25-0030

Approval Date: February 5, 2026

Effective Date: October 1, 2025

Supersedes Transmittal Number: ND-25-0017



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:

Benefit Provided:

Chiropractic

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20 visits per Benefit Period

Duration Limit:

None

Scope Limit:

Exclusions: Maintenance Care that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life.

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

Exclusions Continued: This includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms in order to promote health and to prevent further problems. No benefits available over the 20 visits per benefit period.

Benefit Provided:

Chemotherapy Service

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:

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Commercial HMO

Remove



Alternative Benefit Plan

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:

Benefit Provided:

Anesthesia by Local Infiltration

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:

Benefit Provided:

Urgent Care Services

Source:

Base Benchmark Commercial HMO

[Remove](#)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Exclusion: No out of network coverage.

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

Coverage: medical care provided for a condition that, without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily functions, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require Urgent Care include abdominal pain of unknown origin, unremitting new symptoms of



Alternative Benefit Plan

dizziness of unknown cause, and suspected fracture. Urgent Care requires timely face-to-face medical attention within twenty-four (24) hours of Enrollee notification of the existence of an urgent condition.

Benefit Provided:

Home Health Care Non Rehab

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Exclusions include: Dietitian Services, homemaker services, social worker services, maintenance care, custodial care, food or home delivered meals or respite care.

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

Member must be home-bound to receive home health services. The following is covered if approved by the Plan in lie of Hospital or Skilled Nursing Facility: part-time or intermittent care by a RN or LPN/LVN; part-time or intermittent home health aide services for direct patient care only; physical, occupational, speech, inhalation, and intravenous therapies up to maximum benefit allowable; and/or medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized

Benefit Provided:

Dental Injury

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Must be received within 6 months of date of injury

Scope Limit:

Exclusions include: routine dental care and treatment; natural teeth replacements including crowns, bridges, braces or implants; extraction of wisdom teeth; hospitalization for extraction of teeth;

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

Continued exclusions: dental x-rays or dental appliances; shortening of the mandible or maxillae for cosmetic purposes; services and supplies related to ridge augmentation, implantology, and preventative vestibuloplasty; dental appliances of any sort, including but not limited to bridges, braces, and retainers (except for appliances for treatment of TMJ/TMD).

Benefit Provided:

Dialysis

Source:

Base Benchmark Commercial HMO

Remove

Alternative Benefit Plan

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:

[Remove](#)

Benefit Provided:

Other Licensed Practitioner - OLP

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:

Attachment 3.1-A Item 6.d and Attachment 3.1-B Item 6.d

- Psychologists
- Certified Registered Nurse Anesthetist
- Nurse Practitioners who meet North Dakota's advanced educational and clinic practice requirements and who are certified in specialties in addition to family and pediatric nurse practitioner services.
- Clinical Social worker
- Registered Pharmacist
- Physician Assistants and Clinical Nurse Specialists
- Marriage and Family Therapists and Licensed Professional Clinical Counselors
- Professional Counselor

[Add](#)



Alternative Benefit Plan

2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided:

Emergency Room - Facility

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:

Benefit Provided:

Ambulance Transportation Services

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage is to the nearest provider equipped to furnish the necessary health care services.

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

Not Covered: Services and/or travel expenses relating to a non-emergency medical condition; and complications from a non-covered procedure or service.

Benefit Provided:

Emergency Room - Professional

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:



Alternative Benefit Plan

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



Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided: Inpatient Medical and Surgical care	Source: Base Benchmark Commercial HMO	<input type="button" value="Remove"/>
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Exclusions: Inpatient services performed primarily for diagnostic examinations, Physical Therapy, rest cure, convalescent care, Custodial Care, Maintenance Care or sanitaria care.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
Benefit Provided: Bariatric Surgery	Source: Base Benchmark Commercial HMO	<input type="button" value="Remove"/>
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: Once per Lifetime	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: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
Benefit Provided: Organ and Tissue Transplants	Source: Base Benchmark Commercial HMO	<input type="button" value="Remove"/>
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Excludes: donor organs or tissue other than human donor organs or tissue.		

Alternative Benefit Plan

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

Benefit Provided:

Anesthesia

Source:

Base Benchmark Commercial HMO

[Remove](#)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Administration of Medically Appropriate and Necessary anesthesia for a covered surgical procedure when ordered by the attending Professional Health Care Provider and provided by or under the direct supervision of an Anesthesiologist or Professional

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

Continued: Health Care Provider other than the operating surgeon or the assistant surgeon.

Benefit Provided:

Hospice

Source:

Base Benchmark Commercial HMO

[Remove](#)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefits are provided only for the treatment of Members diagnosed with a condition where there is a life expectancy of 6 months or less.

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

Benefit Provided:

Reconstructive Surgery

Source:

Base Benchmark Commercial HMO

[Remove](#)

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Surgery to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

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

Exclusions: Cosmetic surgery will not qualify as reconstructive surgery when performed for the treatment of a psychological or psychiatric condition. Services or procedures with the primary purpose to improve appearance and not primarily to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes, or which primarily improve or alter body features which are variations of normal development.

Add

Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:

Delivery and Maternity Services

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

2 ultrasounds per pregnancy

Duration Limit:

None

Scope Limit:

Covers prenatal through postnatal maternity care and delivery and care for complications of pregnancy of the mother.

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

Benefits for Inpatient maternity services allow a minimum stay of 48 hours for a vaginal delivery and 96 hours for a cesarean delivery. The Health Care Provider, after consulting with the mother, may discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

Benefit Provided:

Pre and Postnatal Care

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Includes prenatal through postnatal maternity care and delivery and care for complications of pregnancy of the mother. Up to 2 routine ultrasounds per pregnancy to determine fetal age, size and development are allowed.

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



Alternative Benefit Plan

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

Collapse All

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.

Benefit Provided:

Mental Health Inpatient Treatment

Source:

Base Benchmark Commercial HMO

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Not Covered: Psychiatric services in an IMD (Institution for Mental Disease).

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

Benefits are available for the Inpatient treatment of psychiatric illness, including management of medical problems related to an eating disorder diagnosis, when provided by an appropriately licensed and credentialed Hospital or Psychiatric Care Facility. Precertification may be required for Inpatient Hospital Admissions.

Benefit Provided:

Substance Use Disorder Inpatient treatment

Source:

Base Benchmark Commercial HMO

Authorization:

Prior Authorization

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:

Benefits are available for the Inpatient treatment of substance abuse, including medically managed Inpatient detoxification, medically monitored Inpatient detoxification, medically managed intensive Inpatient treatment or medically monitored intensive Inpatient treatment, when provided at an appropriately licensed and credentialed Substance Abuse Facility.

Benefit Provided:

Mental Health Outpatient Treatment

Source:

Base Benchmark Commercial HMO

Authorization:

Prior Authorization

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:

Covered: Home and Office Visits: Benefits Including assessment, counseling, Behavioral Modification Intervention for Autism Spectrum Disorder (Including Applied Behavioral Analysis (ABA)), treatment planning, coordination of care, psychotherapy and group therapy provided by a licensed and/or credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Precertification may be required.

Benefit Provided:

Substance Abuse Disorder Outpatient Treatment

Source:

Base Benchmark Commercial HMO

[Remove](#)

Authorization:

Prior Authorization

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: Home and Office Visits: Benefits Including assessment, counseling, treatment planning, coordination of care, psychotherapy, group therapy and Opioid Treatment Program provided by a licensed and/or credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Benefits are available in an Opioid Treatment Program for opioid use disorder when provided by an appropriately licensed and credentialed Opioid Treatment Program.

[Add](#)



Alternative Benefit Plan

■ 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.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

Retail outpatient pharmacy benefits are administered by the Department of Human Services and not by BCBSND.



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.

Benefit Provided:

Physical, Speech and Occupational Therapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

This benefit covers both habilitation and rehabilitation.

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

Benefit Provided:

Cardiac Rehab

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:

Benefit Provided:

Durable Medical Equipment

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to Plan Guidelines

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

Prior authorization and/or limitations may apply to certain items per the Plan guidelines (available upon request).

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

Benefit Provided:

Prosthetics and Orthotics

Source:

Base Benchmark Commercial HMO

Remove**Authorization:**

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to Plan Guidelines

Duration Limit:

None

Scope Limit:

Prior authorization and/or limitations may apply to certain items per the Plan guidelines (available upon request).

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

Covers: fitting and necessary adjustments of Prosthetic Appliances or Limbs and supplies that replace all or part of an absent body part, standard Prosthetic Appliances and Limbs only, repairs when Medically Appropriate and Necessary (precertification needed), externally worn breast prostheses and surgical bras, including necessary replacements following mastectomy, subject to a Maximum Benefit Allowance of 2 external prostheses and 2 bras per Member per Benefit Period, double mastectomy, allow a Maximum Benefit Allowance of 4 external prostheses and 2 bras per Member per Benefit Period.

Not Covered: dental appliances, artificial organs or Prosthetic Appliances and Limbs intended only for cosmetic purposes. Orthotic Devices available over the counter or those required for leisure or recreational activity or to allow a Member to participate in a sport activity unless Medically Appropriate and Necessary and approved. Prosthetic Limbs or components intended only for cosmetic purposes or customized coverings for terminal devices. Benefits are not available for Prosthetic Limbs or components required for work-related tasks, leisure or recreational activities or to allow a Member to participate in sport activities.

Benefit Provided:

Skilled Nursing Facility

Source:

Base Benchmark Commercial HMO

Remove**Authorization:**

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

30 days per Member per Benefit Period

Duration Limit:

None

Scope Limit:

Exclusions: Maintenance Care or Custodial Care



Alternative Benefit Plan

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

No benefits available over the 30 days per benefit period.

Benefit Provided:

Home Health Care - Rehab (PT, OT, Speech Therapy)

Source:

Base Benchmark Commercial HMO

[Remove](#)

Authorization:

Prior Authorization

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:

This benefit covers both habilitation and rehabilitation.

[Add](#)



Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:

Diagnostic Services

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to Plan Guidelines

Duration Limit:

None

Scope Limit:

Prior authorization and/or limitations may apply to certain items per the Plan guidelines

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

A Diagnostic Service must be ordered by a Professional Health Care Provider. Diagnostic Services include but are not limited to X-ray and other imaging services, laboratory and pathology services, cardiographic, encephalographic and radioisotope tests.

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).

Benefit Provided:

Colorectal Cancer Screening

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Benefit Provided:

Nutritional Counseling

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to Plan Guidelines

Duration Limit:

None

Scope Limit:

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

Hyperlipidemia – Maximum Benefit Allowance of 4 visits per Member per Benefit Period.
 Gestational Diabetes – Maximum Benefit Allowance of 4 visits per Member per Benefit Period.
 Diabetes Mellitus – Maximum Benefit Allowance of 4 visits per Member per Benefit Period.
 Hypertension – Maximum Benefit Allowance of 2 visits per Member per Benefit Period.
 PKU – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.

Benefit Provided:

Tobacco Cessation Counseling Services

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

[Remove](#)

Benefit Provided:

Allergy Services

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Includes: Including serum, direct skin testing and patch testing when ordered by a Professional Health Care Provider

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

Exclusions: testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Re buck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test. The following methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Autoinjections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy. This exclusion also includes clinical ecology, orthomolecular therapy, vitamins or dietary nutritional supplements, or related testing provided on an Inpatient or Outpatient basis.

[Remove](#)

Benefit Provided:

Family Planning

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefits include contraceptive services, sexually transmitted disease testing, follow up care, reproductive health services and sterilizations.



Alternative Benefit Plan

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

Contraceptive services include Injections for birth control purposes, Diaphragm or cervical cap, Surgical implantation and removal of a contraceptive device, Insertion and removal of an Intrauterine Device (IUD), Outpatient surgical sterilization and related services. See Inpatient and Outpatient Surgical Services, Contraceptive Prescription Medications and Drugs, Including birth control pills, patches and vaginal rings.

Benefit Provided:

Diabetes Equipment, Supplies, Education

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Coverage includes: Gestational Diabetes – Maximum Benefit Allowance of 4 visits per Member per Benefit Period, Diabetes Mellitus – Maximum Benefit Allowance of 4 visits per Member per Benefit Period, Diabetes care services include Outpatient Home and Office Visits, Diagnostic Services, Outpatient Nutritional Care Services, Diabetes Education Services, Dilated Eye Examinations and Diabetes Supplies, Diabetes Prevention Program services for Members meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled through a Diabetes Prevention Provider. Palliative or cosmetic foot care, foot support devices (including custom made foot support devices) or subluxations of the foot, care of corns, bunions (except for capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. Benefits are available for custom diabetic shoes and inserts, and the care of corns, calluses and toenails when Medically Appropriate and Necessary for Members with diabetes

Benefit Provided:

Wellness Services

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Coverage includes: Preventive Screening Services, Immunizations, Routine Diagnostic Screenings, Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening for Members age 45 and older, Prostate Cancer Screening for Members age 40 and older, Intensive Behavioral



Alternative Benefit Plan

Interventions for Obesity, Nutritional Counseling, Outpatient Nutritional Care Services
(Including Feeding and Eating Disorder, Diabetes Education Services, Diabetes Prevention Program, Dilated Eye Examination (for diabetes related diagnosis), Tobacco Cessation Counseling Services

Add



Alternative Benefit Plan

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

[Collapse All](#)

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

Secretary-Approved Other

[Remove](#)

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

N/A

Duration Limit:

N/A

Scope Limit:

N/A

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

ND Medicaid member ages 19-20 are enrolled in separate ABP

[Add](#)



Alternative Benefit Plan

11. Other Covered Benefits from Base Benchmark

Collapse All

Other Base Benefit Provided: Vision Services	Source: Base Benchmark	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: Other	Duration Limit: None	
Scope Limit: Exclusions see below:		
Other information regarding this benefit: <p>Coverage is only for Dilated Eye Examination (for diabetes related diagnosis) Benefits are subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period.</p> <p>Exclusions: Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, except as specifically allowed in the Schedule of Benefits and Covered Services Sections of this Benefit Plan. No benefits are available for routine vision examinations. No benefits are available for refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses or complications resulting from refractive surgery. No benefits are available for eyeglasses or contact lenses following cataract surgery.</p>		



Alternative Benefit Plan

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

[Collapse All](#)



Alternative Benefit Plan

13. Other Base Benchmark Benefits Not Covered

Collapse All

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Newborn Coverage

Source:

Base Benchmark

Explain why the state/territory chose not to include this benefit:

This Benefit Plan does not cover newborns or dependents. Members who become pregnant will have an opportunity to change to North Dakota's Traditional Medicaid program.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Residential Treatment Room and Board Coverage

Source:

Base Benchmark

Explain why the state/territory chose not to include this benefit:

Exclusion: Room and board at a vocational residential rehabilitation center, a community reentry program, Halfway House or Group Home.

Alternative Benefit Plan

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:	Source:
1915(i) Behavioral Health HCBS	Section 1937 Coverage Option Benchmark Benefit Package
Authorization:	Provider Qualifications:
Prior Authorization	Medicaid State Plan
Amount Limit:	Duration Limit:
None	None
Scope Limit:	
None	
Other:	
Services must be determined medically necessary by the state. The service are limited to individuals with a behavioral health diagnosis along with a completed WHODAS assessment reviewed and approved by the state.	

Other 1937 Benefit Provided:	Source:
Access to Clinical Trials	Section 1937 Coverage Option Benchmark Benefit Package
Authorization:	Provider Qualifications:
Other	Medicaid State Plan
Amount Limit:	Duration Limit:
None	None
Scope Limit:	
No Authorization is required for this service.	
Other:	

Coverage: Routine individual costs include all items and services consistent with the coverage that is typical for a qualified individual who is not enrolled in a clinical trial. Such items include: services of a physician, diagnostic or laboratory tests, other services provided during the course of treatment for a condition or one of its complications that are consistent with the usual and customary standard of care.

Exclusions: The investigational item, device, or service, itself; the costs of any non-health service that might be required for a person to receive the treatment or intervention (e.g., transportation, hotel, meals, and other travel expenses), costs of managing the research, or items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the individual; or costs which would not be covered under the member's contractual benefits for non-investigational treatments, service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

Other 1937 Benefit Provided:	Source:
Other Licensed Practitioners - OLP	Section 1937 Coverage Option Benchmark Benefit Package
Authorization:	Provider Qualifications:
Other	Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Attachment 3.1-A Item 6.d and Attachment 3.1-B Item 6.d

- Licensed Registered Nurse
- Licensed School Psychologist

Other 1937 Benefit Provided:

Community Health Worker (CHW)

Remove

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

104 Units

Duration Limit:

None

Scope Limit:

Other:

Attachment 3.1-A Item 13.c and Attachment 3.1-B Item 13.c

Services Covered:

- Health System Navigation and Resource Coordination
- Health Promotion and Coaching
- Health Education and Training

Additional visits allowed with prior authorization

Other 1937 Benefit Provided:

Comm Paramedics and Emergency Medical Tech

Remove

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

50 visits in a year

Duration Limit:

None

Scope Limit:

Services must be referred by a physician or Other Licensed Practitioner within their scope of practice according to state law.

Other:

Attachment 3.1-A Item 13.c and Attachment 3.1-B Item 13.c

Services Covered:

- In-home assessments and chronic disease monitoring
- Post-hospital discharge follow-ups

Transmittal Number: ND-25-0030

Approval Date: February 5, 2026

Effective Date: October 1, 2025

Supersedes Transmittal Number: ND-25-0017



Alternative Benefit Plan

- Medication compliance checks
- Referrals to social and mental health services
- Preventive care and health education

Additional visits allowed with prior authorization

Add



Alternative Benefit Plan

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.

V.20190808