A. The following charges are imposed on the categorically needy for services other than those provided under sections 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determination
	Deduct	Coinsurance	Copayment	
Prescription Drugs			X	$3.30 for each prescription filled or refilled for single-source or brand name drugs. The average payment per brand name prescription is $224 per claim.
			X	$1.00 for each prescription filled or refilled for generic or multi-source drugs. The average payment for generic prescriptions is $25.
Physicians			X	$3.00 for each ofice visit, home visit, hospital admission, general ophthalmological service, or medical psychotherapy service. The average payment for physicians' services is $50.34 per claim.
Outpatient Hospital		X		5% of allowable payment amount, excluding laboratory services, for each non-emergency service.
Durable Medical Equipment		X		5% of allowable payment amount.
Prosthetic Devices		X		5% of allowable payment amount.
Medical Supplies			X	$2.00 for each supply
Dental Services			X	$3.00 for each procedure. The average payment per visit for adult dental is $108.28 per visit.
Dentures			X	$3.00 for each complete denture or reline of complete denture.
Mental Health Centers		X		5% of allowable payment amount.
Chiropractic			X	$1.00 for each procedure. The average payment for chiropractic services is $14.09 per claim.
Rural Health Clinics			X	$3.00 for each visit. The average payment for RHC/FQHC services is $85.22 per visit.
Hospital-Based Rural Health Clinics			X	$3.00 for each visit. The average payment for RHC/FQHC services is $85.22 per visit.
Federally Qualified Health Centers			X	$3.00 for each visit. The average payment for RHC/FQHC services is $85.22 per visit.
Inpatient Hospital			X	$50.00 per non-emergent admission (DRG payment).
Podiatry			X	$2.00 per visit. The average payment for podiatry services is $26.89 per claim.
Optometric			X	$2.00 per visit. The average payment for optometric services is $50.92 per claim.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH DAKOTA

D The procedures for implementing and enforcing the exclusions from cost sharing contained in sections 1916(a) and (j) of the Act and 42 CFR 447 53(b) are described below:

During claims processing the recipient's age at date of service is determined using the date of birth from the eligibility file; services related to pregnancy are determined from procedure/diagnosis coding; institutionalization status is determined from the eligibility file; emergency service claims are coded by the provider as emergency services; family planning services are identified on the procedure/diagnosis file; there are no HMO enrollees in the state.

Further, services provided to American Indian/Alaska Natives, whether directly by Indian Health Service (IHS) facilities or an Indian Tribe, Tribal Organization, or Urban Indian Organization (ITU), or referred by an ITU to other, external providers, are exempt from co-payment. The system adds to the recipient's record an indicator that the recipient has received services at an ITU. The State will run weekly updates of the MMIS system to update the co-payment waiver indicator on the recipient's eligibility file based on paid claims data. Individuals who present a letter or other document verifying current or previous use of services provided at an ITU facility, or services referred through contract health services in any State, will be flagged as exempt from cost sharing.

E. Cumulative maximums on charges:

_X_ State policy does not provide for cumulative maximums.

___ Cumulative maximums have been established as described below: