TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Emergency Rule
LSA Document #07-876(E)

DIGEST

Temporarily adds provisions affecting applicants, members, and providers concerning eligibility, enrollment, benefits, and policy for the Indiana check-up plan. Authority: IC 4-22-2-37.1; IC 12-15-44-19(b). Effective December 17, 2007.

SECTION 1. **Under IC 12-15-44, the office hereby adopts and promulgates this document to:**
(1) interpret and implement the provisions of IC 12-15-44;
(2) ensure the efficient, economical, medically reasonable, and quality operations of the Indiana check-up plan;
(3) support healthy behaviors and personal responsibility; and
(4) safeguard against overutilization, fraud, abuse, and the utilization of services and supplies that are not covered under the plan or are not medically reasonable and necessary.

SECTION 2. **(a) The plan shall be operated in compliance with approved federal waiver and expenditure authorities and special terms and conditions established by the Department of Health and Human Services (DHHS). To the extent not expressly waived, the plan shall also be operated in compliance with Title XIX of the Social Security Act and any regulations promulgated thereunder.**

(b) Except as provided in subsection (c), the plan shall be operated in compliance with state Medicaid statutes.

(c) The following state Medicaid statutes shall not apply to the plan:
(1) IC 12-15-6 (individual contributions; copays).
(2) IC 12-15-12 (managed care).
(3) IC 12-15-13 (provider payment; clean claims; timing; overpayment).
(4) IC 12-15-14 (payment to nursing facilities).
(5) IC 12-15-15 (payment to hospitals).
(6) IC 12-15-21 (rules).
(7) IC 12-15-26 (prior authorization for mental health services).
(8) IC 12-15-31.1 (adjustment of pharmacy dispensing fee).
(9) IC 12-15-34 (home health services).
(10) IC 12-15-35 (drug utilization review).
(11) IC 12-15-35.5 (mental health drugs).
(12) IC 16-42-22-10 (generic substitution for Medicaid).

SECTION 3. **(a) The definitions in this SECTION apply throughout this document.**

(b) "Applicant" means an individual for whom coverage under the plan is requested.

(c) "Association" means the Indiana comprehensive health insurance association established by IC 27-8-10-2.1.

(d) "Caretaker relative" means a person in any of the following groups who is living in the home of a dependent child and has the primary responsibility for the care and control of the dependent child:
(1) Any blood relative, including those of half-blood, and including first cousins, nephews, or nieces, and persons of preceding generations as denoted by prefixes of grand, great, or great-great.
(2) Stepfather, stepmother, stepbrother, and stepsister.
(3) Person who legally adopts a child or his parent as well as the natural and other legally adopted children of such persons, and other relatives of the adoptive parents in accordance with state law.
(4) Spouse of any persons named in the above groups even after the marriage is terminated by death or divorce.

(e) "Childless adult" means a nonpregnant individual over nineteen (19) years of age who does not meet the definition of caretaker relative in this document.

(f) "Conditional eligible" means a person determined eligible for the plan by the division who has not yet made his first POWER account contribution.

(g) "Coverage term" means the continuous period of plan eligibility. Except in cases outlined in SECTION 10 of this document, enrollees are permitted to participate in the plan for a period of twelve (12) months.

(h) "Covered service" means a service provided to an enrollee for which payment is available under the plan, subject to the limitations set forth in this document and in manuals, bulletins, or other documentation published by the insurers, association, and the office.

(i) "Deductible" means the amount of covered medical services for which the member or enrollee is responsible.

(j) "Division" means the division of family resources or its agents.

(k) "Emergency medical condition" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:
(1) place an individual's health in serious jeopardy;
(2) result in serious impairment to the individual's bodily functions; or
(3) result in serious dysfunction of a bodily organ or part of the individual.

(l) "Emergency services" means covered services necessary to evaluate or stabilize an emergency medical condition.

(m) "Enhanced services plan-eligible condition" or "ESP-eligible condition" means a complex medical condition that, as determined by the office, requires a high degree of medical services for appropriate treatment or puts an individual at risk of exceeding the maximum coverage limitations set forth in SECTION 17 of this document *[renumbered SECTION 18 of this document by the Publisher]***.**

(n) "Enhanced services plan" or "ESP" means the delivery system component of the plan that includes health benefits, enhanced disease management services, and access to a specialized network that is a necessary part of the disease management services.

(o) "Enrollee" means an individual whom the division has determined to be eligible for the plan and whose first POWER account contribution amount was received and processed by the insurer or association.

(p) "Enrollment broker" means an entity that contracts with the state to inform applicants and members about, and enroll them with, insurers participating in the plan.

(q) "Family planning services" means services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy including, but not limited to, birth control pills and nonoral contraceptives. Family planning services also include sexually transmitted disease testing. Elective abortions and abortifacients are excluded from the definition of family planning services.

(r) "Insurer" means a health insurer or health maintenance organization that has contracted with the office to provide a high deductible health plan and POWER account to individuals enrolled in the plan.

(s) "Medically necessary service", as used in this document, means a covered service that, in a manner consistent with accepted standards of medical practice, is reasonably expected to:
(1) prevent or diagnose the onset of an illness, injury, condition, primary disability, or secondary disability;
(2) cure, correct, reduce, or ameliorate the physical, mental, cognitive, or developmental effects of an illness, injury, or disability; or
(3) reduce or ameliorate the pain or suffering caused by an illness, injury, condition, or disability.

(t) "Member" means an individual whom the division has determined to be eligible for the plan and whose first POWER account contribution amount was received and processed by the insurer or

association.

(u) "Office" means the office of Medicaid policy and planning in the Indiana family and social services administration or its designee.

(v) "Plan" means the "Indiana check-up plan", established by IC 12-15-44, that provides a health care benefit package to eligible individuals through a high deductible health plan paired with a personal health spending account called a POWER account.

(w) "Plan reimbursement rate" means the level of reimbursement insurers pay to providers participating in the plan. This level shall not deviate from the minimum level set forth in IC 12-15-44-14.

(x) "Preventive care services" means care that is provided to an individual to prevent disease, diagnose disease, or promote good health.

(y) "Prior authorization" or "prior approval" or "prior review and authorization" or "prior review and approval" means the procedure for the insurer's or association's prior review and authorization, modification, or denial of coverage for medical services and supplies within plan allowable limitations, based upon medical necessity and other criteria as established by insurers and the association that have been approved and published by the office under SECTION 26 of this document *[renumbered SECTION 28 of this document by the Publisher]***.**

(z) "POWER account" or "personal wellness and responsibility account" means a personal health spending account used to pay an enrollee's deductible for plan covered benefits and services.

(aa) "Provider" means an individual, state or local agency, and corporate or business entity that meets the requirements of 405 IAC 5-4-1. A provider enrolled as a Medicaid provider under 405 IAC 5-4 is eligible to participate in the plan.

(bb) "Secretary" means the secretary of the Indiana family and social services administration.

(cc) "State" means state of Indiana and its administrative agencies.

SECTION 4. **(a) An application for the plan must be made in the manner required by the office.**

(b) An application may be made through:
(1) the division of family resources;
(2) an enrollment center authorized by the division; or
(3) an online method determined by the division.

(c) Applicants must answer any and all health screening questions on the application form regarding the applicant's health status. This information will be used to screen for ESP enrollment pursuant to SECTION 14 of this document *[renumbered SECTION 15 of this document by the Publisher]***.**

(d) An applicant shall sign an application if the applicant is medically able to sign. If an applicant is medically unable to sign an application, the applicant's next of kin, authorized representative, or legal representative, may sign the application.

(e) An electronic signature may be used if the division elects to accept electronic signatures.

(f) An enrollment broker may assist plan applicants in choosing an insurer.

(g) An applicant who fails to choose an insurer will be assigned to an insurer by the office.

(h) An enrollment center that completes initial intake processing for an applicant shall forward the completed application and all required documentation materials to the division.

(i) The date of application is the date a signed application is received by the division or, in the case of an application filed at an enrollment center, the date a signed application is received by the enrollment center.

(j) If an applicant fails or refuses to provide information or verification of information required to determine the applicant's eligibility for the plan or if the applicant fails or refuses to answer all of the health screening questions on the application or to sign the required consent to release medical documents, the applicant shall be ineligible and the application shall be denied. Prior to denying an application under this SECTION, the division shall provide the applicant written notice of the specific information or verification needed to determine eligibility and written notice of the date on which the application will be denied if the information or verification is not provided.

(k) An eligibility determination notice shall be sent to the applicant by the division within forty-five (45) days of date of the application.

SECTION 5. **The effective date of coverage is the first day of the month following the month in which an insurer or association has received and processed the first POWER account contribution for an individual who was determined by the division to be eligible for the plan.**

SECTION 6. **(a) Except as provided in SECTION 11 of this document, an individual is eligible for participation in the plan if the individual meets the following requirements:**
(1) The individual is at least nineteen (19) years of age and less than sixty-five (65) years of age.
(2) The individual is an Indiana resident.
(3) The individual has income as determined under SECTION 8 of this document of not more than two hundred percent (200%) of the federal poverty level for the individual's family size.
(4) The individual is not eligible for health insurance coverage through the individual's employer.
(5) The individual has been without health insurance coverage for at least six (6) consecutive calendar months prior to applying for the plan. This subsection shall not apply to individuals who have exhausted their COBRA continuation coverage or individuals who have lost eligibility for Medicaid in the previous six (6) months.
(6) For purposes of this SECTION, coverage described in IC 27-8-5-2.5 shall not be considered health insurance coverage.

(b) There is no asset test for the plan.

(c) The following individuals are not eligible for the plan:
(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).
(2) A pregnant woman, for purposes of pregnancy-related services. To obtain pregnancy-related services, pregnant women must apply to be transferred to a different Medicaid aid category and will no longer be covered under the plan. Enrollment in more than one (1) aid category is not permitted.
(3) An individual who is eligible for any other aid category in the Medicaid program. For purposes of this subdivision, if an individual is eligible and enrolled under any other aid category in the Medicaid program, such individual shall not be eligible for the plan.

SECTION 7. **(a) For purposes of determining eligibility for the plan and the calculation of the POWER account contribution, family members are the applicant/member and the following individuals who live with the applicant/member:**
(1) The legal spouse of the applicant/member.
(2) The biological, adoptive, and stepchildren under age eighteen (18) of the applicant/recipient, unless the countable income of the child, as determined under *[sic]* **exceeds the child income standard specified in paragraph (b)** *[subsection (b)]***.**
(3) Children under age eighteen (18) of whom the applicant/member is a caretaker relative as defined in SECTION 3(c) of this document *[renumbered SECTION 3(d) of this document by the Publisher]***, unless the countable income of the child, as determined under SECTION 8 of this document, exceeds the child income standard specified in paragraph (b) of this SECTION** *[subsection (b)]***.**

(b) The child income standard is one-twelfth (1/12) of two hundred percent (200%) of the additional person add-on amount specified in the federal poverty guidelines.

(c) The total number of the family members constitutes the family size of the applicant/member.

SECTION 8. **(a) Income is all money received by the family members defined in SECTION 7(a) of this document and is used for the purpose of determining eligibility for the plan and the amount of the POWER account contribution.**

(b) The computations in this subsection shall be made to establish countable gross income. Income received other than monthly shall be converted to a monthly amount as follows:
(1) Income received weekly shall be multiplied by four and three-tenths (4.3).
(2) Income received every two (2) weeks shall be multiplied by two and fifteen-hundredths (2.15).
(3) Income received twice per month shall be multiplied by two (2).
(4) Income received on a quarterly, semiannual, or annual basis shall be divided by the appropriate number of months to establish the monthly amount.
(5) Fluctuating income will be averaged to determine a monthly amount.
(6) Self-employment income is annualized even for seasonal businesses or those in which work does not normally occur twelve (12) months every year.

(c) In addition to the income specifically excluded under state and federal law, the following income is excluded:
(1) Assistance provided by a township trustee or other agency that provides in-kind assistance based on need through vendor payments.
(2) Nonexempt educational income which is paid directly to the school or vendor for tuition, fees, and other educational expenses.
(3) Tax refunds.
(4) A loan shall not be considered as income in the month of receipt if the written or verbal loan agreement is legally binding under state law and includes all of the following:
(A) The borrower's acknowledgment of an obligation to repay.
(B) A timetable and plan for repayment.
(C) The borrower's expressed intent to repay either by pledging real or personal property or anticipated income.
(5) Home energy assistance administered or funded by the office of the lieutenant governor of the state of Indiana.
(6) Supplemental Security Income.

(d) Countable self-employment income is determined by subtracting from the total income the deduction listed in clause (A) *[renumbered subdivision (1) by the Publisher]* **or (B)** *[renumbered subdivision (2) by the Publisher]* **as follows, whichever is greater:**
(1) Forty percent (40%) of the gross income.
(2) Actual business expenses directly tied to the production of income as follows when there is proof of such expenses:
(A) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.
(B) The cost of shelter in the form of rent, mortgage, or contract payments, including interest, taxes, and utilities.
(C) The cost of inventory, machinery, and equipment in the form of rent, loans, direct purchase, and contract payments, including the interest on the loans or contract payments.
(D) Insurance on the real and personal property of the business.
(E) The cost of repairs on the business equipment or shelter.
(F) The cost of any travel required. If the actual cost cannot be determined, twenty-five cents ($0.25) per mile shall be used to calculate the expense.

(e) The following deductions are subtracted from an individual's gross earned income:
(1) Ninety dollars ($90).
(2) The cost of child care not to exceed two hundred dollars ($200) for children under age two (2) and one hundred seventy-five dollars ($175) for children age two (2) and older.

(f) Fifty dollars ($50) is deducted from child support income.

SECTION 9. **(a) An applicant who is approved to participate in the plan shall be eligible for a twelve (12) month period unless the enrollee fails to make POWER account contributions or becomes ineligible under the rules established under SECTION 10 of this document.**

(b) In order to continue participation in the plan, an enrollee must complete the recertification process every twelve (12) months. During the recertification process, the enrollee shall complete a renewal application on a form prescribed by the office and submit it, and any necessary documentation, to the division. The individual's insurer, or association, if applicable, may assist the individual in the renewal application process.

(c) The state shall notify members ninety (90) days before the end of their coverage term that they must apply for continued coverage.

(d) If an enrollee does not submit a complete renewal application before the end of the individual's twelve (12) month coverage term, the individual shall be disenrolled from the plan and may not reapply to participate in the plan for a period of twelve (12) months.

(e) An individual enrolled in the plan may not be refused renewal of participation for the sole reason that the plan has reached the plan's maximum enrollment.

SECTION 10. **(a) During the twelve (12) month coverage period, an individual will become ineligible to participate in the plan under the following circumstances:**
(1) The individual is no longer an Indiana resident.
(2) The individual obtains access to employer sponsored health insurance through his employer.
(3) The individual becomes insured with health insurance other than the plan.
(4) The individual is delinquent in making POWER account contributions, as described in SECTION 54 of this document *[renumbered SECTION 57 of this document by the Publisher]***.**
(5) The individual requests in writing that coverage be terminated.
(6) The individual meets one (1) or more of the criteria in SECTION 6(c) (1), (2) and (3) of this document *[SECTION 6(c)(1) through 6(c)(3) of this document]***.**

(b) Coverage will be terminated for an individual who loses eligibility pursuant to this SECTION.

(c) An individual who falsified information on an application in order to obtain plan benefits may be held financially responsible for the amount of payments made on their behalf by the state, including POWER account contributions.

SECTION 11. **(a) The maximum enrollment of individuals who may participate in the plan is dependent upon the funding appropriated for the plan. The division of family resources may cease accepting applications and shall stop enrolling new applicants when notified by the office that the plan has reached, or is close to reaching, maximum enrollment.**

(b) An applicant who meets the eligibility requirements set forth in this document may not enroll in the plan if the division has ceased enrolling new applicants due to a lack of available funds.

(c) Persons who are enrollees at the time enrollment limits have been reached shall not be denied the opportunity to renew their participation in the plan for the sole reason that the plan has reached maximum enrollment.

(d) A woman who is discontinued from the plan solely because of pregnancy and for whom health coverage has been transferred to Medicaid shall not be denied the opportunity to reapply for participation in the plan for the sole reason that the plan has reached maximum enrollment, if she reapplies not later than sixty (60) days after her pregnancy ends.

SECTION 12. **(a) In the event that the rights, duties, obligations, privileges, or other legal relations of any person or entity are required or authorized by law to be determined by the office or the division of family resources, then such person or entity may request an administrative hearing under this SECTION.**

(b) Appeals by plan members and applicants are governed by the procedures and time limits for Medicaid applicants and recipients set out in 405 IAC 1.1.

SECTION 13. **A member dissatisfied with the action of an insurer or association must exhaust the insurer's or association's internal grievance and appeals procedure prior to requesting a hearing by the state. The grievance and appeals procedures established by the insurers and the association must comply with 42 CFR 438, Subpart F.**

SECTION 14. **(a) Except as provided in subsection (c), if a member requests a hearing prior to the effective date of a notice of discontinuance of coverage, or increase in the POWER account contribution, plan coverage will continue without change until the administrative law judge issues a decision after the hearing pursuant to 405 IAC 1.1-1-6, unless the member specifically requests that the proposed action be**

taken. The member must continue to make contributions to the POWER account in order to continue coverage.

(b) If the division's action is sustained at the administrative level, the member is responsible for repaying the cost of any services furnished by reason of this SECTION, minus any contributions made for coverage during the pendency of the appeal.

(c) If the member is notified that coverage is to be discontinued due to nonpayment of the member's contributions, plan coverage will not be maintained after the effective date of the discontinuance.

SECTION 15. **(a) Each applicant shall be asked to complete a series of enhanced services plan (ESP) screening questions during the plan application process. An applicant must answer all ESP screening questions before his or her plan application will be deemed complete.**

(b) If an applicant's answers to the ESP screening questions on the plan application indicate the possible existence of a complex medical condition, the applicant who has been determined eligible for the plan will be enrolled in an enhanced services plan specifically designated to provide health care services to ESP-eligible individuals.

(c) The office shall review the placement of the applicant in the ESP and determine whether or not the placement was appropriate, based on one (1) or more of the following:
(1) review of the applicant's answers to the ESP screening questions on the plan application;
(2) review of the applicant's medical records;
(3) communication or other outreach to the applicant's provider(s);
(4) review of some or all of the applicant's past claims history, if available and accessible; or
(5) other review processes, as determined by the office.

(d) If the office determines that an applicant was placed appropriately in the ESP, the applicant shall remain enrolled in the ESP. If the office determines that enrollment in the ESP was not appropriate, the applicant will be enrolled with the insurer selected on the individual's plan application. If no insurer was selected, the applicant will be auto-assigned to an insurer.

SECTION 16. **(a) The enhanced services shall be administered through a fee for service delivery system administered by the association.**

(b) The association shall provide medical management services.

(c) Enrollees shall have access to those members of the association's provider network for the health insurance plan established under IC 27-8-10 who are also enrolled as Medicaid providers.

(d) Reimbursement to providers shall be at plan reimbursement rates except that pharmacy services shall be reimbursed at Medicaid rates.

SECTION 17. **For a benefit or service to be covered under the plan, it must:**
(1) be medically necessary, as defined in SECTION 3(r) of this document *[renumbered SECTION 3(s) of this document by the Publisher]***; and**
(2) not be listed in this document as a noncovered service or otherwise excluded from coverage.

SECTION 18. **(a) The following services are covered under the plan according to the coverage criteria, limitations, and procedures specified in this document and in manuals, bulletins, or other documentation published by the insurers, association, and the office:**
(1) Mental health care services.
(2) Inpatient hospital services.
(3) Skilled nursing facility services, subject to a thirty (30) day maximum.
(4) Prescription drug coverage.
(5) Emergency room services, including nonemergent services provided in an emergency setting.
(6) Physician office services.
(7) Diagnostic services, including pregnancy testing.
(8) Outpatient services, including covered therapy services.
(9) Comprehensive disease management.
(10) Home health services, including case management.

(11) Urgent care center services.
(12) Preventive care services.
(13) Family planning services.
(14) Hospice services.
(15) Substance abuse services.
(16) Durable medical equipment.
(17) Lead screening services and hearing aids for nineteen (19) and twenty (20) year olds.
(18) Any other enhanced services the insurer or association offers, in accordance with the terms of the insurer's policy or the association's plan.

(b) The following per enrollee reimbursement limitations apply:
(1) An annual individual maximum reimbursement limitation of three hundred thousand dollars ($300,000).
(2) A lifetime individual maximum reimbursement of one million dollars ($1,000,000).

(c) Individuals that may exceed the maximum coverage limitations established in this SECTION shall be notified by the office or its designee and referred for potential eligibility in other programs.

SECTION 19. **Coverage of mental health care services shall be subject to the same treatment limitations or financial requirements as coverage of services for physical illness.**

SECTION 20. **Covered therapy services include physical, occupational, and speech therapy and are subject to the following limitations:**
(1) Physical therapy services shall be limited to a twenty-five (25) visit annual maximum.
(2) Occupational therapy services shall be limited to a twenty-five (25) visit annual maximum.
(3) Speech therapy services shall be limited to a twenty-five (25) visit annual maximum.

SECTION 21. **(a) Covered disease management services shall include disease management for the following conditions:**
(1) diabetes;
(2) congestive heart failure;
(3) asthma;
(4) chronic kidney disease; and
(5) such other conditions as may be determined by the office.

(b) Insurers and the association may provide disease management programs for other conditions not listed in this SECTION. Additional disease management programs must be approved by the office.

SECTION 22. **Covered pharmacy benefits and services include brand name and generic prescription drugs and prescribed over-the-counter insulin, subject to the following exclusions:**
(1) Those designated by the Centers for Medicare and Medicaid Services as less than effective, or identical, related, or similar to a less than effective drug.
(2) Pharmaceutical abortifacients.
(3) Sexual dysfunction medication.
(4) Weight loss medications.
(5) Physician samples dispensed in a physician's office.
(6) Brand name drugs, where generic substitution is possible, in accordance with applicable law. Brand name drugs with generic equivalents are covered if the insurer or the association determines either of the following:
(A) the brand name drug is medically necessary; or
(B) the brand name drug is less costly than the generic; and
(7) Such other drugs as the office may determine.

SECTION 23. **Covered laboratory services include only laboratory services provided by laboratories or providers with Clinical Laboratory Improvement Amendments (CLIA) certificates.**

SECTION 24. **(a) The first five hundred dollars ($500) of covered preventive services is not subject to the deductible. Covered preventive services in excess of five hundred dollars ($500) are subject to the deductible.**

(b) The office shall develop an annual list of age, gender, and preexisting condition preventive

service goals for members based on U.S. Centers for Disease Control and Prevention guidelines and publish the list by December 1 each year.

(c) The office shall provide the list developed under subsection (b) to an individual who participates in the plan. Enrollees must receive preventive services applicable to them in order to qualify for the full carry forward of POWER account funds described in SECTION 47 of this document *[renumbered SECTION 50 of this document by the Publisher]***.**

SECTION 25. **(a) Members shall be subject to the following copayments for nonemergency use of a hospital emergency department:**

(1) Childless adults are subject to a twenty-five dollar ($25) copayment. However, the copayment shall not apply if the member is admitted to the hospital on the same day as the visit.

(2) Caretaker relatives are subject to copayments as follows:

(A) Caretaker relatives with a family income at or below one hundred percent (100%) of the federal poverty level are subject to a three dollar ($3) copayment.

(B) Caretaker relatives with a family income above one hundred percent (100%) of the federal poverty level and at or below one hundred and fifty percent (150%) of the federal poverty level are subject to a six dollar ($6) copayment.

(C) Caretaker relatives with a family income above one hundred and fifty percent (150%) of the federal poverty level and at or below two hundred percent (200%) of the federal poverty level are subject to a copayment equal to the lesser of twenty percent (20%) of the cost of the services provided during the emergency room visit or twenty-five dollars ($25).

(b) The hospital must inform the member after receiving an appropriate medical screening examination under Section 1867 of the Social Security Act and after a determination has been made that the individual does not have an emergency medical condition, but before providing the nonemergency services, of the following:

(1) The hospital may require the payment of the applicable copayment listed in subsection (a) before the service can be provided.

(2) The name and location of an alternate nonemergency services provider that is actually available and accessible.

(3) The fact that such alternate provider can provide the services without imposition of the copayment listed in subsection (a).

(4) The hospital provides a referral to coordinate scheduling of this treatment.

(c) Providers shall be responsible for collecting emergency room copayments incurred under this SECTION.

(d) Members may not use their POWER account to pay for emergency room copayments incurred under this SECTION.

SECTION 26. **The following services are covered, even if provided out-of-network:**

(1) Family planning services.

(2) Emergency medical services.

(3) Medically necessary covered services, if the enrollee's insurer or the association is unable to provide the services in-network within thirty (30) miles of the enrollee's residence for primary care and sixty (60) miles of the enrollee's residence for specialty care.

(4) Nurse practitioner services, if the enrollee's insurer or the association is unable to provide the services in-network within sixty (60) miles of the member's residence.

(5) Services provided by federally qualified health centers (FQHCs) and rural health centers (RHCs).

SECTION 27. **Enrollees may receive the following covered services without a referral from their primary medical provider or prior authorization or precertification from their insurer or the association:**

(1) Family planning services.

(2) Emergency medical services.

(3) Federally qualified health center and rural health center services.

SECTION 28. **(a) An insurer and the association may implement utilization control procedures, including prior authorization or precertification of services. Services furnished by the insurer and the association must be sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished.**

(b) The office shall publish the prior authorization procedures used by each insurer and the association. The procedures shall be published as a provider bulletin and may be updated from time to time. The initial publication and any updates shall be made effective no earlier than forty-five (45) days after the date the bulletin is mailed. The bulletin shall include all information necessary for a provider to submit a prior authorization request to the insurer and the association.

(c) A provider that has an agreement with the office and that renders services to an enrollee must follow the procedures published under subsection (b) whether that provider has a contract with the insurer or not.

(d) Decisions by insurers and the association regarding prior authorization and precertification shall be made as expeditiously as possible considering the circumstances of each request. If no decision is made within fourteen (14) working days of receipt of all documentation required, authorization is deemed to be granted.

(e) The following services are exempt from any procedures established under this SECTION:
(1) Emergency services.
(2) Family planning services.
(3) Federally qualified health center and rural health center services.

SECTION 29. **The following services are not covered under the plan:**
(1) Services which are not medically reasonable and necessary.
(2) Maternity and related services.
(3) Dental services.
(4) Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly.
(5) Vision services.
(6) Elective abortions and abortifacients.
(7) Nonemergency transportation services. For purposes of this SECTION, nonemergency transportation services are defined as transportation services that are unrelated to an emergency medical condition as defined in SECTION 3(j) of this document *[renumbered SECTION 3(k) of this document by the Publisher]***.**
(8) Chiropractic services.
(9) Drugs excluded from the plan pursuant to SECTION 21 of this document *[renumbered SECTION 22 of this document by the Publisher]***.**
(10) Long term or custodial care.
(11) Experimental and investigative services, as determined by the office.
(12) Daycare and foster care.
(13) Personal comfort or convenience items.
(14) Cosmetic services, procedures, equipment, or supplies, and complications directly relating to cosmetic services, treatment, or surgery, with the exception of reconstructive services performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or a previous medically necessary procedure.
(15) Hearing aids and associated services, except for nineteen (19) and twenty (20) year olds.
(16) Safety glasses, athletic glasses, and sunglasses.
(17) LASIK and any surgical eye procedures to correct refractive errors.
(18) Vitamins, supplements, and over-the-counter medications, with the exception of insulin.
(19) Wellness benefits other than tobacco use cessation.
(20) Diagnostic testing or treatment in relation to infertility.
(21) In vitro fertilization.
(22) Gamete or zygote intrafallopian transfers.
(23) Artificial insemination.
(24) Reversal of voluntary sterilization.
(25) Transsexual surgery.
(26) Treatment of sexual dysfunction.
(27) Body piercing.
(28) Over-the-counter contraceptives.
(29) Alternative or complementary medicine including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, massage therapy, and herbal, vitamin, or dietary products or therapies.

(30) Treatment of hyperhydrosis.
(31) Court ordered testing or care, unless medically necessary.
(32) Travel related expenses including mileage, lodging, and meal costs, except for mileage paid to emergency transportation providers.
(33) Missed or canceled appointments for which there is a charge.
(34) Services and supplies provided by, prescribed by, or ordered by immediate family members, such as spouses, caretaker relatives, siblings, in-laws, or self.
(35) Services and supplies for which an enrollee would have no legal obligation to pay in the absence of coverage under the plan.
(36) The evaluation or treatment of learning disabilities.
(37) Routine foot care, with the exception of diabetes foot care.
(38) Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot, and tarsalgia.
(39) Any injury, condition, disease, or ailment arising out of the course of employment if benefits are available under any worker's compensation act or other similar law.
(40) Examinations for the purpose of research screening.

SECTION 30. **Insurers, the association, and providers shall not charge, collect, or impose cost sharing, including premiums, copayments, or coinsurance to plan enrollees for covered services, except in the following circumstances:**
(1) Deductible amounts paid for with funds out of an enrollee's POWER account.
(2) Emergency room copayments, as set forth in SECTION 23 of this document *[renumbered SECTION 25 of this document by the Publisher]***.**

SECTION 31. **(a) Members shall remain enrolled with the same insurer during the member's twelve (12) month coverage term. Members may request to change insurers only in the following circumstances:**
(1) Before making their first POWER account contribution, or within sixty (60) days of being assigned to an insurer, whichever comes first. The insurer shall print prominently in its first communication with conditional eligibles a notice stating in substance that the individual may change insurers before making the first POWER account contribution, or within sixty (60) days of being assigned to an insurer, whichever comes first.
(2) For cause, at any time after exhausting the insurer's internal grievance and appeals process. Members who are not satisfied with the results of the insurer's grievance and appeals process may submit a request to change insurers to the enrollment broker. If the request is not granted, the member may file an appeal with the state. However, if the request is not acted upon by the first day of the second month following the month in which the enrollee files the request, the request will be deemed approved and the enrollee will be transferred to the new insurer.

(b) For purposes SECTION (a)(2) *[subsection (a)(2)]***, "for cause" is defined as poor quality of health care coverage and includes, but is not limited to, the following:**
(1) Failure of the insurer to provide covered services.
(2) Failure of the insurer to comply with established standards of medical care administration.
(3) Significant language or cultural barriers.
(4) Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

(c) The state shall also notify members that they may change insurers without cause at the time they submit their application for a second or subsequent coverage term.

(d) This SECTION shall not apply to individuals assigned to the enhanced services plan.

SECTION 32. **(a) Qualified individuals not enrolled in the plan shall be able to purchase, without a state subsidy, the plan benefit package from participating insurers. Insurers, or their affiliates, shall offer the same health insurance coverage provided under the plan for purchase to the following qualified individuals:**
(1) Individuals eligible for the plan unable to participate due to enrollment limitations.
(2) Individuals not eligible for the plan, so long as the individual has been uninsured during the previous six (6) months.

(b) Coverage provided under the buy-in program shall be the same as coverage under the plan; however, insurers will have the right to offer additional riders to buy-in program participants.

(c) No state funding will be provided for the buy-in health insurance coverage provided pursuant to this SECTION, nor will individuals have any appeal rights with the state for any actions taken by insurers concerning the buy-in program.

SECTION 33. **(a) In offering buy-in coverage to individuals eligible for the plan but unable to participate due to enrollment limitations, insurers, or their affiliates, shall charge the individual the same amount for buy-in health insurance coverage that the insurer would have received in POWER account contributions and capitation payments from the office had the individual been able to participate in the plan.**

(b) In offering buy-in coverage pursuant to individuals not eligible for the plan but uninsured for the previous six (6) months, insurers, or their affiliates, may apply standard individual or small group insurance underwriting and rating practices.

SECTION 34. **(a) Insurers and the association must notify enrollees who are, or are likely to become, pregnant that pregnancy services are not covered under the plan. Insurers and the association must refer pregnant enrollees to the division and assist such enrollees in transferring to a different aid category of the Medicaid program.**

(b) Pregnancy related claims submitted to plan insurers and the association will not be paid under the plan. Such claims will be paid under the fee for service Medicaid program, provided that proof of pregnancy that meets Medicaid standards has been submitted.

SECTION 35. **(a) With the exception of emergency services providers, a provider providing covered services to enrollees must be enrolled in the Indiana Medicaid program at the time of service. Emergency services providers who are not enrolled in the Indiana Medicaid program at the time of service must enroll in the Indiana Medicaid program retroactive to the date of service in order to receive reimbursement.**

(b) Reimbursement is available only for claims filed by providers certified and enrolled in the Medicaid program effective at the time the service is rendered.

(c) The procedures set out in 405 IAC 5-4-1 for enrollment of providers in the Medicaid program applies to providers under this document who render covered services to plan enrollees.

(d) A provider providing covered services to enrollees shall provide the services under a contract with an insurer except in the following circumstances:

(1) A provider may provide the covered services listed in SECTION 24 of this document *[renumbered SECTION 26 of this document by the Publisher]* **without a contract with an insurer.**

(2) A provider may provide covered services without a contract with an insurer if the insurer has designed an out-of-network benefit for its members or otherwise approves the out-of-network service.

SECTION 36. **(a) The right of providers contracting with insurers or the association to dispute any actions taken by the insurer or the association is governed by the provider's contract with the insurer or association.**

(b) The reimbursement dispute resolution procedure set forth at 405 IAC 1-1.6 shall apply to providers who do not have a contract with an insurer or the association for services provided under the plan.

(c) Any provider disputes involving prior authorization determinations made by the insurers or association are governed by the insurers' or association's procedures for provider grievances and appeals.

(d) There is no right to appeal a plan action to the state for either a contracted or noncontracted provider.

SECTION 37. **(a) Before providing any service covered by the plan, each provider must verify the eligibility for the plan and enrollment with an insurer or the association of the individual for whom the**

service is provided. Failure to do so may result in denial of the provider's claim if the individual is not enrolled in the plan or the service is not authorized. The provider must determine all of the following:

(1) The individual is enrolled in the plan at the time the service is being provided.

(2) The individual whose name appears on the card is the same individual for whom the service is being performed.

(3) The service is covered under the provisions of SECTION 17 of this document *[renumbered SECTION 18 of this document by the Publisher]***.**

(b) If an individual is disenrolled from an insurer or the association while receiving inpatient hospital services covered under the plan, the insurer or the association shall pay any claims related to the covered inpatient hospital services provided to the member through the date of discharge.

SECTION 38. **The provisions of 405 IAC 1-5-1 and 405 IAC 1-5-2 concerning contents, retention, and disclosure of records of Medicaid providers apply to providers under this document.**

SECTION 39. **(a) Reimbursement to providers contracting with insurers is governed by the contract between the provider and the insurer.**

(b) Reimbursement to providers without contracts who render services to plan enrollees is governed by IC 12-15-44-14(a)(2).

(c) No provider retains any independent or duplicative right for reimbursement from the office in addition to or in lieu of reimbursement received from the insurer or the association.

SECTION 40. **(a) A provider shall be reimbursed for covered services as follows:**

(1) Until the member's deductible is met, with POWER account funds accessed through the member's POWER account card. If the member lacks sufficient POWER account funds at the time of service, the insurer or the association must pay for any portion of the plan reimbursement rate that cannot be paid with POWER account funds but shall reconcile these prepaid amounts as additional POWER account funds are received from the member.

(2) For the first five hundred dollars ($500) of covered preventive services, by the insurer or the association.

(3) For covered services under the member's health plan after the deductible has been met, by the insurer or the association. The provider shall be reimbursed at the plan reimbursement rate.

(4) For covered services provided out-of-network, if the out-of-network provider lacks the capacity to conduct the transaction using the enrollee's card, the insurers or the association will reimburse the out-of-network provider with funds from the member's POWER account. The insurers and the association may also reimburse in-network providers with funds from the member's POWER account if the in-network providers lack the capacity to conduct the transaction using the member's card.

(b) A plan provider shall not be reimbursed for any portion of the reimbursement rate for covered services that is in excess of the maximum coverage limitations established in SECTION 17 of this document *[renumbered SECTION 18 of this document by the Publisher]***.**

(c) Reimbursement is not available for services provided to individuals who are not enrolled in the plan on the date the service is provided except as required under SECTION 34(b) of this document *[renumbered SECTION 36(b) of this document by the Publisher]***.**

SECTION 41. **Providers must accept plan reimbursement as payment in full. A plan provider cannot collect from an enrollee any portion of the provider's charge for a covered service that is not reimbursed by the insurer or the association, with the exception of the following:**

(1) emergency room copayments authorized under this document;

(2) payments made with POWER account funds before the deductible of the enrollee's health plan is met; or

(3) the difference between a brand name drug and its generic substitute when only the cost of the generic substitute is covered by the insurer or the association.

SECTION 42. **(a) The insurer or the association shall establish and administer a POWER account in the name of each individual enrolled in the plan. The maximum amount that may be contributed to the POWER account is one thousand one hundred dollars ($1,100) per year. Contributions to the account may be made by the state, the enrollee in whose name the account is established, and the enrollee's employer.**

(b) POWER account funds must be used to pay the deductible for health care services covered under the plan.

(c) Members will not earn interest on their POWER accounts.

SECTION 43. **(a) Each enrollee is responsible for the use of funds in his or her POWER account until the deductible is met. POWER account funds can only be used to pay for covered services.**

(b) Enrollees are permitted to use POWER account funds to pay for covered services described in SECTION 24 of this document *[renumbered SECTION 26 of this document by the Publisher]***, even if obtained through out-of-network providers.**

SECTION 44. **Enrollees shall not use POWER account funds to pay:**
(1) The emergency room services copayment described in SECTION 23 of this document *[renumbered SECTION 25 of this document by the Publisher]***.**
(2) Any other cost not listed in SECTION 40 of this document *[renumbered SECTION 43 of this document by the Publisher]***.**

SECTION 45. **(a) Enrollees are required to contribute to their POWER account based on a sliding scale as follows:**
(1) The POWER account contribution for enrollees with annual household income of one hundred percent (100%) of the federal poverty level or less must not exceed two percent (2%) of their annual household income.
(2) The POWER account contribution for enrollees with annual household income above one hundred percent (100%) of the federal poverty level and at or below one hundred twenty-five percent (125%) of the federal poverty level must not exceed three percent (3%) of their annual household income.
(3) The POWER account contribution for enrollees with annual household income above one hundred twenty-five percent (125%) of the federal poverty level and at or below one hundred fifty percent (150%) of the federal poverty level must not exceed four percent (4%) of their annual household income.
(4) Caretaker relatives with annual household income above one hundred fifty percent (150%) of the federal poverty level and at or below two hundred percent (200%) of the federal poverty level must not exceed four and five-tenths percent (4.5%) of their annual household income.
(5) Childless adults with annual household income above one hundred fifty percent (150%) of the federal poverty level and at or below two hundred percent (200%) of the federal poverty level must not exceed five percent (5%) of their annual household income.

(b) Enrollee POWER account contribution amounts are reduced to account for other payments made for Medicaid, the children's health insurance program (CHIP), or Medicare.

SECTION 46. **(a) The state shall contribute the difference between the enrollee's annual contribution calculated pursuant to SECTION 46** *[renumbered SECTION 49 of this document by the Publisher]* **or 47** *[renumbered SECTION 50 of this document by the Publisher]* **of this document and one thousand one hundred dollars ($1,100).**

(b) An enrollee's employer may make, from funds not payable by the employer to the employee, not more than fifty percent (50%) of the employee's share of the POWER account contribution.

SECTION 47. **(a) Plan coverage begins on the first day of the month following the month in which the insurer or the association has received and processed the first POWER account payment for an individual who was determined by the division to be eligible for the plan.**

(b) If the first payment has not been made within sixty (60) days of the due date, the individual will no longer be considered conditionally eligible and will be required to reapply for the plan. Such individuals may reapply at any time.

SECTION 48. **Enrollees may change insurers before making their first POWER account contribution or within sixty (60) days of being assigned to an insurer, whichever comes first. After the first POWER account contribution is made, they may not change insurers without cause for the duration of the twelve (12) month eligibility period.**

SECTION 49. **For an enrollee's first term of coverage, contributions to the POWER account are determined in the following manner:**

(1) Monthly family income and family size are calculated to determine the maximum required contribution percentage, as described in SECTION 42 of this document *[renumbered SECTION 45 of this document by the Publisher]***.**

(2) Monthly family income is multiplied by the contribution percentage to determine the maximum monthly contribution.

(3) Contributions made for Medicaid, the children's health insurance program (CHIP), or Medicare are identified and subtracted from the maximum monthly contribution to determine the monthly contribution amount.

SECTION 50. **(a) For enrollees who remain eligible for the plan at the end of the coverage term, POWER account contributions shall be recalculated by the state as part of the redetermination process. This may occur after the new coverage term has begun.**

(b) If some or all of an enrollee's POWER account balance is rolled over at the end of the coverage term, the amount of the enrollee's POWER account contribution for the new coverage term shall be reduced by the amount of the enrollee's rolled-over account balance from the previous coverage term. Insurers or the association must notify the enrollee of this roll-over amount, as well as the new amount to be billed to the enrollee in equal monthly installments in the new coverage term.

(c) For an enrollee's second term of coverage and subsequent coverage terms, POWER account contributions are determined in the following manner:

(1) Steps described in SECTION 46 of this document *[renumbered SECTION 49 of this document by the Publisher]* **that are used to calculate first term contribution are repeated for the next coverage term.**

(2) Remaining balance of POWER account from previous coverage term is determined.

(3) If preventive services goals established under SECTION 22 of this document *[renumbered SECTION 24 of this document by the Publisher]* **were met, remaining balance is subtracted from the annual contribution amount for the next coverage term to determine adjusted required contribution.**

(4) Adjusted required contribution is divided by twelve (12) to determine monthly contribution.

(5) If preventive services goals were not met, total enrollee and employer contributions from the previous year are calculated and divided by one thousand one hundred dollars ($1,100). This ratio is multiplied by the total amount remaining in the enrollee's POWER account, and the result is subtracted from the annual contribution amount for the next coverage term to determine the adjusted required contribution.

(6) Adjusted required contribution is divided by twelve (12) to determine monthly contribution.

SECTION 51. **(a) If an enrollee loses plan eligibility due to nonpayment of POWER account contributions, as specified in SECTION 54 of this document** *[renumbered SECTION 57 of this document by the Publisher]***, the enrollee shall be paid a portion of the balance remaining in his or her POWER account. This amount is calculated as follows: Total enrollee and employer contributions made during the latest coverage period are calculated and divided by the total amount paid into the POWER account from all sources. This ratio is multiplied by the total amount remaining in the individual's POWER account. The result is multiplied by seventy-five hundredths (.75) to determine the amount to be returned to the individual.**

(b) If an enrollee loses plan eligibility for other reasons, as specified in SECTION 10(a)(1) through (4) and (6) through (7) *[sic]* **of this document, the enrollee shall be paid a portion of the balance remaining in his or her POWER account, calculated as follows: Total enrollee and employer contributions made during the latest coverage period are calculated and divided by the total amount paid into the POWER account from all sources. This ratio is multiplied by the total amount remaining in the enrollee's POWER account, and the result is returned to the individual.**

(c) The insurer or the association must return the prorated share of any POWER account balance within sixty (60) days of the enrollee's last date of participation with the insurer or the association, less any amount paid on the member's behalf. The remaining balance must be credited back to the state. If the insurer or the association receives claims for covered services with dates of service during the prior coverage period after the POWER account balance has been paid to a former enrollee and these claims require a POWER account payment, the insurer or the association may bill the former enrollee for the POWER account portion of such services.

(d) Employer contributions to POWER accounts are considered part of the enrollee's contribution for purposes of calculating POWER account balance amounts to be returned to individuals.

(e) Any remaining POWER account balances must be remitted to the state.

(f) In the event that an enrollee cannot be located or otherwise does not claim the prorated share of the POWER account balance made available under this SECTION, the insurer or the association shall handle the unclaimed balance pursuant to the Unclaimed Property Act (IC 32-34-1, et seq.).

SECTION 52. **(a) In some cases, the one thousand one hundred dollar ($1,100) deductible will be met before an enrollee has made all of his or her required contributions. The fact that a POWER account may not yet have been fully funded does not relieve the insurer or the association of the responsibility to pay providers for covered services rendered. Insurers or the association may deduct amounts owed by the enrollee from future POWER account contributions.**

(b) If an enrollee ends participation in the plan before the conclusion of his or her twelve (12) month coverage term and the insurer or the association has made an advance payment of the deductible that has not been repaid through enrollee POWER account contributions, the insurer or the association may collect from the individual. All collection activities must be approved by the office. The state will require the individual to settle any debts owed to insurers or the association before the individual can return to the plan.

SECTION 53. **(a) An enrollee may request a recalculation of his or her POWER account contribution at any time during each twelve (12) month enrollment period if the individual experiences a change in family size (e.g., death, divorce, birth, family member moving out of household). An individual may also request a recalculation each time the individual experiences a qualifying event.**

(b) Insurers and the association shall inform individuals of any circumstances in which they may request a POWER account contribution recalculation during a coverage term, explain that the individual may only request a recalculation once in each twelve (12) month period for changes in income, and that the individual is responsible for notifying the state about changes in income that may affect eligibility.

(c) For purposes of this SECTION, a "qualifying event" is defined as job loss or other change in income.

SECTION 54. **(a) Insurers or the association shall bill and collect the enrollee's required POWER account contribution.**
(1) Enrollees may pay their required contribution in equal monthly installments.
(2) Families may make combined payments on behalf of all family members enrolled in the plan, with payments distributed evenly among the POWER accounts of each family member.

(b) Insurers and the association must provide enrollees with the following contribution payment options:
(1) Acceptance of automatic payroll deduction.
(2) U.S. mail.
(3) Cash, money order, cashier's check, and personal check.
(4) Employer withholding (after taxes), pursuant to IC 12-14-44-10 *[sic]***.**

(c) Insurers and the association may offer additional options for making the required contribution.

(d) After plan coverage begins, subsequent POWER account contributions paid by check must be available for enrollee use within five (5) calendar days after the check has cleared. Contributions paid by money order must be available for enrollee use within five (5) calendar days of payment receipt.

SECTION 55. **Insurers and the association are required to monitor employer contributions to ensure that they do not exceed fifty percent (50%) of the individual's contributions. Insurers and the association are not required to accept payroll contributions from more than one (1) employer.**

SECTION 56. **(a) Since the first POWER account installment of the new coverage term may become due before the enrollee's individual contribution has been recalculated by the state, the enrollee may be**

billed by the insurer or the association according to the prior year's required contribution schedule.

(b) The insurer or the association must reconcile any overpayments or underpayments made by an enrollee as a result of paying the prior coverage period amount for the subsequent coverage period within thirty (30) days of notification by the state of the enrollee's recalculated contribution amount for the new coverage term.

SECTION 57. **(a) Insurers and the association shall establish monthly due dates for payment of POWER account contributions.**

(b) If payments are not made timely, the insurer and the association must inform the enrollee in writing of his or her nonpayment. The demand for payment shall be sent to the enrollee on or before the seventh calendar day of nonpayment and must state that the enrollee will be referred to the division for disenrollment from the insurer or the association and terminated from participation in the plan if payment is not received. The insurer's or the association's demand for payment must explain that if the enrollee is terminated from participation in the plan, he or she will not be able to reapply to the plan for a period of at least twelve (12) months.

(c) If an enrollee does not make a required monthly contribution within sixty (60) days of its due date, the enrollee will be terminated from participation in the plan and shall be disenrolled from the insurer or association by the division following notice to the enrollee.

(d) Any funds remaining in the POWER account must be credited to the state and returned to the individual as provided *[sic]* **SECTION 48(a) of this document** *[renumbered SECTION 51(a) of this document by the Publisher]***.**

SECTION 58. **(a) An enrollee who voluntarily withdraws from the plan shall remain enrolled in the plan through the end of the last month for which POWER account payments have been made. If the enrollee voluntarily withdraws from the plan prior to making the POWER account payment for the month in which they notify the plan of their withdrawal, the enrollee shall be disenrolled from the plan.**

(b) Disbursement of any funds remaining in the POWER account at the time of disenrollment shall be determined in accordance with SECTION 48 of this document *[renumbered SECTION 51 of this document by the Publisher]***.**

(c) Enrollees who voluntarily withdraw from the plan will be responsible for paying any amounts owed to the insurer, the association, or to providers at the time of disenrollment.

(d) Enrollees who voluntarily withdraw from the plan may not reapply to the plan for a period of at least twelve (12) months.

SECTION 59. **(a) If a member disenrolls from one (1) insurer or the association and transfers to a new insurer or the association, the insurer or the association shall transfer the member's POWER account balance to the state within thirty (30) days.**

(b) If the transfer occurs at the end of a coverage term, the insurer or the association is responsible for determining the amount of the transferring member's permitted roll-over balance, as well as any amounts that must be credited back to the state. The insurer or the association shall forward the roll-over amount to the state and credit the state its share of the account balance, if applicable.

SECTION 60. **(a) Within thirty (30) days of processing the enrollee's first POWER account contribution, insurers or the association shall mail a card to each member to provide the member with access to his or her POWER account funds.**

(b) Each time a contribution to the member's POWER account is made, the insurer or the association must credit the member's POWER account accordingly. An account update shall be sent to the member within thirty (30) days each time a contribution is credited to his or her POWER account or a deduction is made.

(c) The member is allowed to access the POWER account through the card and may use it to pay for services up to the deductible amount. The card may only be used for approved plan benefits delivered by

approved providers.

SECTION 61. **The insurer and the association must make replacement cards available to members who lose or destroy their original cards. The first replacement card must be issued at no cost to the member. Insurers and the association may charge a reasonable fee, as determined by the office, for each additional replacement card.**

SECTION 62. **(a) Electronic communication between insurers or the association and members is encouraged in the plan.**

(b) The insurer or the association may send monthly e-mail communications to the member to direct the member to a secure website to view member account balance information, or the plan can make POWER account balance information available in the form of an electronic account update that will be e-mailed to members on a monthly basis and as changes occur. Members will be directed to a secure website to review other information, such as age and sex appropriate preventative service and utilization reminders, in the monthly account updates. Up-to-date account balance information shall also be available to members online and through the insurers' or the association's member help line.

(c) Explation *[sic]* **of benefit (EOB) statements must be available to members electronically, via a secure website. The electronic EOB statement or member health statement must reflect the change in the member's POWER account balance including benefit balance and funding balance. The year-to-date usage amount must be included on each EOB statement.**

(d) POWER account balance information may also be made available in the form of a receipt at service locations where the POWER account card is used.

SECTION 63. **(a) If an enrollee fails to complete all necessary steps to maintain or renew eligibility in the plan during redetermination, the enrollee will not be permitted to reapply for the plan for a period of at least twelve (12) months.**

(b) The insurer or the association is required to refund the enrollee's pro rata share of his or her POWER account balance, if any, within sixty (60) days of the enrollee's last date of participation in the plan. The amount payable to the member shall be determined in accordance with the process set forth in SECTION 48 of this document *[renumbered SECTION 51 of this document by the Publisher]***. If the insurer or the association receives claims for covered services that would have been paid from the POWER account after the POWER account balance has been paid to a former enrollee, the plan may bill the former enrollee for the POWER account portion of such services.**

SECTION 64. **The insurer and the association must ensure that its members have access to its negotiated provider reimbursement rates under the plan when they are purchasing covered services with POWER account funds. Providers providing covered services under the plan cannot charge the member an amount that exceeds the established plan rate for the covered service.**

SECTION 65. This document expires March 16, 2008.

LSA Document #07-876(E)
Filed with Publisher: December 17, 2007, 3:30 p.m.

Posted: 12/26/2007 by Legislative Services Agency
An html version of this document.