TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Emergency Rule
LSA Document #08-517(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 June 16, 2008.

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 U.S. Department of Health and Human Services. 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 or her 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 subdivisions (1) through (3) even after the marriage is terminated by death or divorce.

(e) "Childless adult" means a nonpregnant individual at least nineteen (19) years of age and less than sixty-five (65) years of age who does not meet the definition of caretaker relative in this document.

(f) "Conditionally eligible" means a plan applicant who has been determined eligible for the plan by the division and is not yet enrolled in the plan.

(g) "Coverage term" means the continuous period of plan eligibility. Except in cases outlined in SECTION 9 of this document, members are permitted to participate in the plan for a period of twelve (12) months.

(h) "Covered service" means a service provided to a member 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) "DEC" means a designated enrollment center authorized by the division to accept applications and complete initial intake processing on applications.

(j) "Deductible" means the amount of covered medical services for which the member is responsible. The amount of the deductible for the plan is one thousand one hundred dollars ($1,100).

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

(l) "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.

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

(n) "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 18(b) of this document.

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

(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. The term "family planning services" also includes 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; and
(4) is not listed in this document as a noncovered service or otherwise excluded from coverage.

(t) "Member" means an individual whom the division has determined to be eligible for the plan and for whom a beginning date of coverage has been established by the division.

(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 amount of reimbursement insurers pay to providers participating in the plan. This amount shall:
(1) not be less than the federal Medicare reimbursement rate for the service provided; or
(2) at a rate of one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

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

(y) "Prior authorization", "prior approval", "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 28 of this document.

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

(aa) "Provider" means an individual, state or local agency, or 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;
(2) DEC 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 15 of this document.

(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) A DEC 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 a DEC, the date a signed application is received by the DEC.

(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 established the POWER account for the conditionally eligible individual and notified the division.**

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. However, individuals who declined enrollment during the employer's open enrollment period are not eligible for the plan.
(5) The individual has been without health insurance coverage for at least six (6) consecutive calendar months. This subdivision 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 27-8-14.1-1(b) 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) An individual enrolled in another Medicaid aid category. Enrollment in more than one (1) aid category is not permitted.
(3) 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.

(d) An applicant who may be eligible for both the plan and another Medicaid aid category shall first be determined for eligibility under the other Medicaid category and may be approved for the plan only if he or she is not eligible for the other aid category, with one (1) exception. An applicant for a disability category may be approved for the plan pending the determination of disability by the office.

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 eighteen (18) years of age of the applicant/recipient, unless the countable income of the child, as determined under SECTION 8 of this document, exceeds the child income standard specified in subsection (b).
(3) Children under eighteen (18) years of age for whom the applicant/member is a caretaker relative as defined in SECTION 3(d) of this document, unless the countable income of the child, as determined under SECTION 8 of this document exceeds the child income standard specified in 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 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 including 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 that 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.

(d) Countable self-employment income is determined by subtracting from the total income the deduction listed in subdivision (1) or (2) as follows:
(1) Forty percent (40%) of the gross income is subtracted if this amount is more than actual expenses described in subdivision (2), the applicant/member requests the forty percent (40%) deduction, or the applicant/member fails to provide documentation of the actual expenses as described in subdivision (2).
(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 two (2) years of age and one hundred seventy-five dollars ($175) for children two (2) years of age and older.

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

(g) If enrollment limits under SECTION 9 of this document are reached, the state may adjust income eligibility standards as permitted in the federally approved waiver.

(h) The amount calculated under this SECTION multiplied by twelve (12) is the annual household income used in SECTION 46 of this document to determine the amount of the POWER account contribution.

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

(b) In order to continue participation in the plan, a member must complete the recertification process every twelve (12) months. During the recertification process, the member shall complete a renewal 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 process; however, the individual retains the ultimate responsibility for submitting any forms and documentation to the division in a timely manner.

(c) If a member does not submit a complete renewal application on or before the forty-fifth day before the end of the individual's twelve (12) month coverage term, the individual shall be disenrolled from the plan and may not participate in the plan for a period of twelve (12) months.

(d) 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 or her employer.
(3) The individual becomes insured with health insurance other than the plan.
(4) The individual becomes eligible for another Medicaid aid category.
(5) The individual is delinquent in making POWER account contributions, as described in SECTION 58 of this document.
(6) The individual requests in writing that coverage be terminated.
(7) The individual meets one (1) or more of the criteria in 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 and enrollment limits established in the federally approved waiver. The division 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 members 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 her date of application is no 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 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) A member dissatisfied with the action of an insurer must exhaust the insurer's internal grievance and appeals procedure prior to requesting a hearing by the state.**

(b) The grievance and appeals procedures established by the insurers must comply with applicable state insurance laws and 42 CFR 438, Subpart F.

(c) After exhausting the insurer's internal grievance and appeals procedures, a member may file an appeal requesting a state hearing thirty (30) days from the date of the insurer's adverse notice of resolution. Such appeal shall be governed by the procedures and time limits set forth in 405 IAC 1.1.

(d) The association shall have a grievance procedure that complies with 42 CFR 438, Subpart F. Appeals of actions taken by the association shall be governed by 405 IAC 1.1.

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 within thirty (30) days of such placement 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, applicant's provider or providers.
(4) Review of some or all of the applicant's past claims history, if available and accessible.
(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. A member shall participate in the

medical management services provided.

(c) Members shall have access to providers who are enrolled as Medicaid providers.

(d) Reimbursement to providers rendering services to ESP members shall be at Medicare fee schedule rates except that pharmacy services, federally qualified health center (FQHC) services, and rural health center (RHC) services shall be reimbursed at Medicaid rates.

(e) Providers rendering services to ESP members are subject to all provisions contained in the Medicaid provider agreement except as amended by this document.

SECTION 17. **For a benefit or service to be covered under the plan, it must:**
(1) be medically necessary, as defined in SECTION 3(s) of this document; 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 sixty (60) 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 as defined in SECTION 20 of this document.
(9) Comprehensive disease management.
(10) Home health services, including case management.
(11) Urgent care center services.
(12) Preventive care services.
(13) Family planning services as defined in SECTION 3(q) of this document.
(14) Hospice services.
(15) Substance abuse services.
(16) Services provided at a federally qualified health center (FQHC) or rural health center (RHC).
(17) Durable medical equipment.
(18) Lead screening services and hearing aids for individuals nineteen (19) years of age or twenty (20) years of age.
(19) Any other enhanced services the insurers or association offers, in accordance with the terms of the insurers' policy or the association's plan.

(b) The following per member 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) Members 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 when the member exceeds two hundred thousand dollars ($200,000) in a year or nine hundred thousand dollars ($900,000) in a lifetime.

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 each 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.
(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.
(B) The brand name drug is less costly than the generic.
(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 a list of required age, gender, and preexisting condition preventive services based on U.S. Centers for Disease Control and Prevention guidelines. Completion of these services are required in order for the state's contribution to the member POWER account to be used toward the members' required POWER account contribution in the subsequent year. The list shall be published list by October 1 each year.

(c) The office shall provide the list developed under subsection (b) to a member. Members must receive preventive services applicable to them in order to qualify for the full carry forward of POWER account funds described in SECTION 51 of this document.

(d) Members are responsible for obtaining and submitting proof to the insurer or association that preventative services were obtained. Instructions for submitting proof will be provided to members by the insurers and the association.

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.
(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 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 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).
(3) The copayment described under subdivisions (1) and (2) shall not apply if the member is admitted to the hospital on the same day as the visit.

(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 member's insurer or the association is unable to provide the services in-network within thirty (30) miles of the member's residence for primary care and sixty (60) miles of the member's residence for specialty care.

(4) Nurse practitioner services.

SECTION 27. **Members 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.

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 insurers and the association.

(c) A provider that has an agreement with the office and that renders services to a member 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) calendar 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.

SECTION 29. **The following services are not covered under the plan:**

(1) Services that are not medically 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.
(8) Chiropractic services, except those services covered under the plan that are within the scope of practice of a chiropractor (e.g., physical therapy).
(9) Drugs excluded from the plan.
(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 individuals nineteen (19) years of age or twenty (20) years of age.
(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, reiki therapy, massage therapy, and herbal, vitamin, or dietary products or therapies.
(30) Treatment of hyperhidrosis.
(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 a member 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. **(a) Insurers, the association, and providers shall not charge, collect, or impose cost sharing, including premiums, copayments, or coinsurance to plan members for covered services, except in the following circumstances:**
(1) Deductible amounts paid for with funds out of a member's POWER account.
(2) Emergency room copayments, as set forth in SECTION 25 of this document.

(b) In those instances where the insurer or the association pays for a service at the Medicare rate, any cost sharing that would typically be applicable in the Medicare program is not applicable and will be included in the rate paid by the insurer or the association.

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 to conditionally eligible individuals 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 in accordance with SECTION 12 of this document. However, if the request is not acted upon by the first day of the second month following the month in which the member files the request, the request will be deemed approved and the member will be transferred to the new insurer.
(3) At redetermination, if the member submits the request to the enrollment broker forty-five (45) days prior to the end of the member's coverage term.

(b) For purposes of subsection (a)(2), "for cause" means 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. These standards are based on those developed by the American Accreditation HealthCare Commission, Inc. and are available upon request.
(3) Significant language or cultural barriers.
(4) Corrective action levied against the insurer by the office.
(5) Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

(c) The state will notify members that they may change insurers without cause forty-five (45) days prior to the end of their coverage term if the member applies 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 under but 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 may 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 and was assigned to an insurer.**

(b) In offering buy-in coverage 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.

(c) The buy-in product must comply with standards established by the Indiana department of insurance.

SECTION 34. **(a) Insurers and the association must notify members who are, or are likely to become, pregnant that pregnancy services are not covered under the plan. Insurers and the association must refer**

pregnant members to the division and assist such members in transferring to a different aid category of the Medicaid program, if requested by the member.

(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 members 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 apply to providers under this document who render covered services to plan members.

(d) A provider providing covered services to members 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 this document 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.
(3) A provider providing covered services to ESP members is not required to have a contract with the association.

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

(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 for services provided under the plan.

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

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

SECTION 37. **(a) A Medicaid provider who renders services to ESP members and who is dissatisfied with the amount of his reimbursement from the association may appeal under the provisions of 405 IAC 1-1.5. However, prior to filing such an appeal, the provider must either:**
(1) resubmit the claim to the association if the reason for denial of payment was due to incorrect or inaccurate billing by the provider;
(2) submit, if appropriate, an adjustment request to the association; or
(3) submit a written request to the association, stating why the provider disagrees with the denial or amount of reimbursement.

(b) All requests for payment adjustments or reconsideration of a claim that has been denied must be submitted to the association within sixty (60) days of the date of notification that the claim was paid or denied. In order to be considered for payment, each subsequent claim resubmission or adjustment request must be submitted within sixty (60) days of the most recent notification that the claim was paid or denied. The date of notification shall be considered to be three (3) days following the date of mailing from the association.

(c) Any provider disputes involving prior authorization determinations are governed by 405 IAC 5-7, except that determinations and administrative reviews shall be conducted by the association.

SECTION 38. **(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 this document.

(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 39. **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 40. **(a) Reimbursement matters including, but not limited to, the time limit for filing claims and rates paid to providers contracting with insurers are governed by the contract between the provider and the insurer.**

(b) Reimbursement rates paid by insurers to providers without contracts who render services to plan members is at plan reimbursement rates governed by IC 12-15-44-14(a)(2). Such providers are subject to all other provisions contained in the Medicaid provider agreement except as amended by this document.

(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.

SECTION 41. **(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 and paid by the insurer or the association. 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.

(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 this document.

(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 38(b) of this document.

SECTION 42. **Providers must accept plan reimbursement as payment in full. A plan provider cannot collect from a member 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 member's health plan is met.

(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 43. **(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 member in whose name the account is established, and the member'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 44. **(a) Each member 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) Members are permitted to use POWER account funds to pay for covered out-of-network services described in SECTION 26 of this document.

SECTION 45. **Members shall not use POWER account funds to pay:**
(1) The emergency room services copayment described in SECTION 25 of this document.
(2) Any other cost not listed in SECTION 18 of this document.

SECTION 46. **(a) For purposes of this SECTION, annual household income is determined under SECTION 8 of this document.**

(b) Members are required to contribute to their POWER account based on a sliding scale as follows:
(1) The POWER account contribution for members 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 members 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 members 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.

SECTION 47. **(a) The state shall contribute the difference between the member's annual contribution calculated pursuant to SECTION 50 or 51 of this document and one thousand one hundred dollars ($1,100).**

(b) A member'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 48. **(a) Plan coverage begins on the effective date of coverage established under SECTION 5 of this document.**

(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 49. **Members 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 50. **For a member'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 46 of this document.
(2) Monthly family income is multiplied by the contribution percentage to determine the maximum monthly contribution.
(3) Premiums paid for Medicaid or the children's health insurance program (CHIP) are identified and subtracted from the maximum monthly contribution to determine the monthly contribution amount.

SECTION 51. **(a) For members 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 a member's POWER account balance is rolled over at the end of the coverage term, the amount of the member's POWER account contribution for the new coverage term shall be reduced by the amount of the member's rolled-over account balance from the previous coverage term. Insurers or the association must notify the member of this rollover amount, as well as the new amount to be billed to the member in equal monthly installments in the new coverage term.

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

(1) Steps described in SECTION 50 of this document 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 recommended preventive care services goals established under SECTION 24 of this document 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 recommended preventive care services goals were not met, total member 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 member'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.
(7) Reconciliation of the POWER account will not occur before one hundred eighty-five (185) days after the end of the coverage term.

SECTION 52. **(a) If a member loses plan eligibility due to nonpayment of POWER account contributions, as specified in SECTION 58 of this document, the member shall be paid a portion of the balance remaining in his or her POWER account. This amount is calculated as follows: Total member 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 a member loses plan eligibility for other reasons, as specified in SECTION 10(a)(1) through 10(a)(4) and 10(a)(7) of this document, the member shall be paid a portion of the balance remaining in his or her POWER account, calculated as follows: Total member 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 member'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 member's last date of participation with the insurer or the association, less any amount paid on the member's behalf. 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 member and these claims require a POWER account payment, the insurer or the association may bill the former member for the POWER account portion of such services.

(d) Employer contributions to POWER accounts are considered part of the member'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 a member 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 53. **(a) In some cases, the one thousand one hundred dollar ($1,100) deductible will be met before a member 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 member from future POWER account contributions.

(b) If a member 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 member POWER account contributions, or if the member owes past due 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.

(1) The amount owed by a member under this SECTION shall be calculated as follows:

(A) Divide member's POWER account contribution amount (as determined under SECTION 50 of this document) by one thousand one hundred dollars ($1,100).

(B) Multiply the amount of claims paid up to one thousand one hundred dollars ($1,100) during the coverage term by the amount determined in clause (A).

(C) Subtract the total monthly individual contributions paid by the member during the coverage term by the amount determined under this clause. The remaining amount is the member's debt.

(2) The member's debt shall be subtracted from any amounts owed by the insurer or association pursuant to SECTION 52(a) or 52(b) of this document before a distribution of the member's portion of the POWER account balance can be paid.

(3) No amount will be owed when the end of participation in the plan is due to the death of the member, transfer to any other Medicaid aid category, or transfer between insurers or an insurer and the association.

(c) Members are also liable for any nonsufficient funds check charges that may be incurred by the plans or association resulting from payment processing.

SECTION 54. **(a) For purposes of this SECTION, a "qualifying event" is defined as job loss or other change in income.**

(b) A member 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 in or out of household). An individual may also request a recalculation one (1) time during each coverage term if the individual experiences a qualifying event.

(c) 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 qualifying events and that the individual is responsible for notifying the division about changes in income that may affect eligibility.

SECTION 55. **(a) Insurers or the association shall bill and collect the member's required POWER account contribution.**

(1) Members 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 members 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 12-15-44-10.

(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 or money order must be available for member use within five (5) calendar days after the check has cleared.

SECTION 56. **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 POWER account contributions from more than one (1) employer. Plans may**

accept one (1) time, lump sum contributions from employers.

SECTION 57. **(a) Since the first POWER account installment of the new coverage term may become due before the member's individual contribution has been recalculated by the state, the member 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 a member 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 member's recalculated contribution amount for the new coverage term.

SECTION 58. **(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 member in writing of his or her nonpayment. The demand for payment shall be sent to the member on or before the seventh calendar day of nonpayment and must state that the member will be referred to the division for disenrollment from the insurer or the association and terminated from participation in the plan if the untimely payment is not received by the due date specified by the insurer or the association. The insurer's or the association's demand for payment must explain that if the member 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 individual's required payment to the plan is not made within sixty (60) days after the required payment date, the member will be terminated from participation in the plan and shall be disenrolled from the insurer or association by the division following notice to the member. Both the untimely payment and the current month's payment must be made to avoid termination and disenrollment.

(d) Any funds remaining in the POWER account must be credited to the state and returned to the individual as provided in SECTION 52(a) of this document.

(e) Members who voluntarily withdraw from the plan are subject to subsection (d) and 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 rollover balance, as well as any amounts that must be credited back to the state. The insurer or the association shall forward the rollover amount to the state and credit the state its share of the account balance, if applicable.

SECTION 60. **(a) Within five (5) days of processing the member's first POWER account contribution, insurers or the association shall issue a card to each member.**

(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 may access the POWER account through the card and may use it to pay for services up to the deductible amount if the insurers and the association make such technology available. The card may only be used for approved plan benefits delivered by approved providers.

SECTION 61. **The insurers and the association must make replacement cards available at no charge to members who lose or destroy their original cards.**

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

(b) The insurers and 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) Explanation 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.

SECTION 63. **(a) If a member fails to complete all necessary steps to maintain or renew eligibility in the plan during redetermination, the member 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 member's pro rata share of his or her POWER account balance, if any, within sixty (60) days of the member'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 52(b) of this document. 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 member, the plan may bill the former member for the POWER account portion of such services, according to SECTION 52(c) of this document.

SECTION 64. **The insurers and the association must ensure that their 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 September 14, 2008.

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