(b) The State must make the public schedule available to the following groups:

(1) Enrollees, at the time of enrollment and reenrollment after a redetermination of eligibility, and when cost-sharing charges and cumulative cost-sharing maximums are revised.

(2) Applicants, at the time of application.

(3) All participating providers.

(4) The general public.

§ 457.530 General cost-sharing protection for lower income children.

The State may vary premiums, deductibles, coinsurance, copayments or any other cost sharing based on family income only in a manner that does not favor children from families with higher income over children from families with lower income.

§ 457.535 Cost-sharing protection to ensure enrollment of American Indians and Alaska Natives.

States may not impose premiums, deductibles, coinsurance, copayments or any other cost-sharing charges on children who are American Indians or Alaska Natives, as defined in § 457.10.

§ 457.540 Cost-sharing charges for children in families with incomes at or below 150 percent of the FPL.

The State may impose premiums, enrollment fees, deductibles, copayments, coinsurance, cost sharing and other similar charges for children whose family income is at or below 150 percent of the FPL as long as—

(a) Aggregate monthly enrollment fees, premiums, or similar charges imposed on a family are less than or equal to the maximum amounts permitted under § 447.52 of this chapter for a Medicaid eligible family of the same size and income;

(b) Any copayments, coinsurance, deductibles or similar charges for children whose family income is at or below 100 percent of the FPL are equal to or less than the amounts permitted under § 447.54 of this chapter;

(c) For children whose family income is from 101 percent to 150 percent of the FPL, any copayments, coinsurance, deductibles or similar charges are equal to or less than the maximum amounts permitted under § 457.555;

(d) The State does not impose more than one type of cost-sharing charge (deductible, copayment, or coinsurance) on a service;

(e) The State only imposes one copayment based on the total cost of services furnished during one office visit; and

(f) Aggregate annual cost sharing of all types, with respect to all targeted low-income children in a family, does not exceed the maximum permitted under § 457.560(a).

[66 FR 2681, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§ 457.555 Maximum allowable cost-sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL.

(a) *Non-institutional services.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State plan must provide that for non-institutional services, including emergency services, the following requirements must be met:

(1)(i) For Federal FY 2009, any copayment or similar charge the State imposes under a fee-for-service delivery system may not exceed the amounts shown in the following table:

State payment for the service	Maximum Copayment
$15 or less	$1.15
$15.01 to $40	$2.30
$40.01 to $80	$3.40
$80.01 or more	$5.70

(ii) Thereafter, any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(2) For Federal FY 2009, any co-payment that the State imposes for services provided by a managed care organization may not exceed $5.70 per visit. In succeeding years, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component

of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(3) Any coinsurance rate the State imposes may not exceed 5 percent of the payment the State directly or through contract makes for the service; and

(4) For Federal FY 2009, any deductible the State imposes may not exceed $3.40 per month, per family for each period of eligibility. Thereafter, any deductible may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(b) *Institutional services.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the maximum deductible, coinsurance or copayment charge for each institutional admission may not exceed 50 percent of the payment the State would make under the Medicaid fee-for-service system for the first day of care in the institution.

(c) *Institutional emergency services.* For Federal FY 2009, any copayment that the State imposes on emergency services provided by an institution may not exceed $5.70. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(d) *Non-emergency use of the emergency room.* For Federal FY 2009, for targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State may charge up to twice the charge for non-institutional services, up to a maximum amount of $11.35 for services furnished in a hospital emergency room if those services are not emergency services as defined in § 457.10. Thereafter, any charge may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(e) *Standard copayment amount.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, a standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in paragraphs (a), (b), and (c) of this section to the State's average or typical payment for that service.

[66 FR 2681, Jan. 11, 2001, as amended at 73 FR 71854, Nov. 25, 2008; 75 FR 30265, May 28, 2010]

§ 457.560 Cumulative cost-sharing maximum.

(a) A State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of a family's total income for the length of a child's eligibility period in the State.

(b) The State must inform the enrollee's family in writing and orally if appropriate of their individual cumulative cost-sharing maximum amount at the time of enrollment and reenrollment.

[66 FR 2681, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

§ 457.570 Disenrollment protections.

(a) The State must give enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

(b) The disenrollment process must afford the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges, and in the event that such a showing indicates that the enrollee may have become eligible for Medicaid or for a lower level of cost sharing, the State must facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate.

(c) The State must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program in accordance with § 457.1130(a)(3).