Volume 41, Number 23
Pages 1751–1890
December 1, 2016

SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JASON KANDER

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

SECRETARY OF STATE

JASON KANDER

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

DIRECTOR

WAYLENE W. HILES

•

MANAGING EDITOR

CURTIS W. TREAT

•

EDITOR

AMANDA MCKAY

•

ASSOCIATE EDITOR

VONNE KILBOURN

•

ASSISTANT EDITOR

MARTY SPANN

•

PUBLICATION TECHNICIAN

JACQUELINE D. WHITE

•

ADMINISTRATIVE ASSISTANT

ALISHA DUDENHOEFFER

ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO

Subscription fee: $56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER

Office of the Secretary of State

Administrative Rules Division

PO Box 1767

Jefferson City, MO 65102

The *Missouri Register* and *Code of State Regulations* (CSR) are now available on the Internet. The Register address is http://www.sos.mo.gov/adrules/moreg/moreg.asp and the CSR is http://www.sos.mo.gov/adrules/csr/csr.asp. These websites contain rulemakings and regulations as they appear in the Registers and CSR. These websites do not contain the official copies of the Registers and CSR. The official copies remain the paper copies published by the Office of the Secretary of State pursuant to sections 536.015 and 536.031, RSMo Supp. 2014. While every attempt has been made to ensure accuracy and reliability, the Registers and CSR are presented, to the greatest extent practicable as they appear in the official publications. The Administrative Rules Division may be contacted by email at rules@sos.mo.gov.

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.

MISSOURI REGISTER

December 1, 2016

Vol. 41 No. 23 **Pages 1751–1890**

IN THIS ISSUE:

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
August 1, 2016	**September 1, 2016**	September 30, 2016	October 30, 2016
August 15, 2016	**September 15, 2016**	September 30, 2016	October 30, 2016
September 1, 2016	**October 3, 2016**	October 31, 2016	November 30, 2016
September 15, 2016	**October 17, 2016**	October 31, 2016	November 30, 2016
October 3, 2016	**November 1, 2016**	November 30, 2016	December 30, 2016
October 17, 2016	**November 15, 2016**	November 30, 2016	December 30, 2016
November 1, 2016	**December 1, 2016**	December 31, 2016	January 30, 2017
November 15, 2016	**December 15, 2016**	December 31, 2016	January 30, 2017
December 1, 2016	**January 3, 2017**	January 31, 2017	February 28, 2017
December 15, 2016	**January 17, 2017**	January 31, 2017	February 28, 2017
January 3, 2017	**February 1, 2017**	February 28, 2017	March 30, 2017
January 17, 2017	**February 15, 2017**	February 28, 2017	March 30, 2017
February 1, 2017	**March 1, 2017**	March 31, 2017	April 30, 2017
February 15, 2017	**March 15, 2017**	March 31, 2017	April 30, 2017
March 1, 2017	**April 3, 2017**	April 30, 2017	May 30, 2017
March 15, 2017	**April 17, 2017**	April 30, 2017	May 30, 2017
April 3, 2017	**May 1, 2017**	May 31, 2017	June 30, 2017
April 17, 2017	**May 15, 2017**	May 31, 2017	June 30, 2017

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

Missouri Participating Libraries

The *Missouri Register* and the *Code of State Regulations*, as required by the Missouri Documents Law (section 181.100, RSMo Supp. 2014), are available in the listed participating libraries, as selected by the Missouri State Library:

Jefferson County Library
PO Box 1486, 3021 High Ridge
High Ridge, MO 63049-1486
(314) 677-8689

Jefferson College Library
1000 Viking Drive
Hillsboro, MO 63050-2441
(314) 789-3951 ext. 160

St. Louis Public Library
1301 Olive St.
St. Louis, MO 63103-2389
(314) 539-0376

St. Louis University Law Library
3700 Lindell Blvd.
St. Louis, MO 63108-3478
(314) 977-2742

Eden/Webster Library
Eden Theological Seminary/
Webster University
475 East Lockwood Ave.
St. Louis, MO 63119-3192
(314) 961-2660 ext. 7812

Thomas Jefferson Library
University of Missouri-St. Louis
8001 Natural Bridge Road
St. Louis, MO 63121-4499
(314) 516-5084

Washington University Law Library
Washington University
Campus Box 1171, Mudd Bldg.,
One Brookings Dr.
St. Louis, MO 63130-4899
(314) 935-6443

St. Louis County Library
1640 S. Lindbergh Blvd.
St. Louis, MO 63131-3598
(314) 994-3300 ext. 247

Library
Maryville University
13550 Conway Road
St. Louis, MO 63141-7232
(314) 529-9494

Pickler Memorial Library
Truman State University
100 E. Normal
Kirksville, MO 63501-4221
(660) 785-7416

Learning Resources Center
Mineral Area College
PO Box 1000
Park Hills, MO 63601-1000
(573) 431-4593

Cape Girardeau Public Library
711 N. Clark
Cape Girardeau, MO 63701-4400
(573) 334-5279

Kent Library
Southeast Missouri State University
One University Plaza
Cape Girardeau, MO 63701-4799
(573) 651-2757

Riverside Regional Library
PO Box 389, 1997 E. Jackson Blvd.
Jackson, MO 63755-0389
(573) 243-8141

Rutland Library
Three Rivers Community College
2080 Three Rivers Blvd.
Poplar Bluff, MO 63901-2393
(573) 840-9656

James C. Kirkpatrick Library
University of Central Missouri
142 Edwards Library
Warrensburg, MO 64093-5020
(660) 543-4149

Kansas City Public Library
14 West 10th Street
Kansas City, MO 64105
(816) 701-3546

Law Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

Miller Nichols Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

B.D. Owens Library
Northwest Missouri State University
800 University Drive
Maryville, MO 64468-6001
(660) 562-1841

St. Joseph Public Library
927 Felix Street
St. Joseph, MO 64501-2799
(816) 232-8151

Hearnes Learning Resources Ctr.
Missouri Western State University
4525 Downs Drive
St. Joseph, MO 64507-2294
(816) 271-5802

Library
North Central Missouri College
PO Box 111, 1301 Main Street
Trenton, MO 64683-0107
(660) 359-3948 ext. 325

Spiva Library
Missouri Southern State University
3950 East Newman Road
Joplin, MO 64801-1595
(417) 625-9342

Missouri State Library
600 West Main, PO Box 387
Jefferson City, MO 65102-0387
(573) 751-3615

Missouri State Archives
600 West Main, PO Box 778
Jefferson City, MO 65102-0778
(573) 526-6711

Elmer Ellis Library
University of Missouri-Columbia
106 B Ellis Library
Columbia, MO 65211-5149
(573) 882-0748

Library
State Historical Society of Missouri
1020 Lowry St.
Columbia, MO 65211-7298
(573) 882-9369

Daniel Boone Regional Library
PO Box 1267, 100 West Broadway
Columbia, MO 65205-1267
(573) 443-3161 ext. 359

School of Law
University of Missouri-Columbia
224 Hulston Hall
Columbia, MO 65211-0001
(573) 882-1125

Smiley Memorial Library
Central Methodist University
411 Central Methodist Square
Fayette, MO 65248-1198
(660) 248-6279

Library
Missouri University of Science and
Technology
1870 Miner Circle
Rolla, MO 65409-0060
(573) 341-4007

Lebanon-Laclede County Library
915 S. Jefferson Ave.
Lebanon, MO 65536-3017
(417) 532-2148

University Library
Southwest Baptist University
1600 University Ave.
Bolivar, MO 65613-2597
(417) 328-1631

Barry-Lawrence Regional Library
213 6th St.
Monett, MO 65708-2147
(417) 235-6646

Lyons Memorial Library
College of the Ozarks
General Delivery
Point Lookout, MO 65726-9999
(417) 334-6411 ext. 3551

Garnett Library
Missouri State University—West
Plains
304 Cleveland
West Plains, MO 65775-3414
(417) 255-7945

Springfield-Greene County Library
4653 S. Campbell
Springfield, MO 65801-0760
(417) 874-8110

Meyer Library
Missouri State University
PO Box 175, 901 S. National
Springfield, MO 65804-0095
(417) 836-4533

HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 41—General Tax Provisions

EMERGENCY AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The department proposes to amend section (1).

PURPOSE: This emergency amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2017.

*EMERGENCY STATEMENT: The director of revenue is mandated to establish not later than October 24 annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percent. This emergency amendment is necessary to ensure public awareness and to preserve a compelling governmental interest requiring an early effective date in that the amendment informs the public of the established rate of interest to be paid on unpaid amounts of taxes for the 2017 calendar year. A proposed amendment, that covers the same material, is published in this issue of the **Missouri Register**. The director has limited the scope of the emergency amendment to the circumstances creating the emergency. The director has followed procedures calculated to assure fairness to all interested persons and parties and has complied with protections extended by the **Missouri** and **United States Constitutions**. Emergency amendment was filed October 21, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(1) Pursuant to section 32.065, RSMo, the director of revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governors of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set by administrative order the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%
2017	**4%**

*AUTHORITY: section 32.065, RSMo 2000. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 21, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (29), (33), (53), and (68); removing sections (9), (21), and (52); adding new sections (30) and (37); and renumbering as necessary.

PURPOSE: This amendment revises the definitions of essential benefits, formulary, out-of-pocket maximum, and specialty medications; removes the definitions of behavior health coaching, disease management, and non-formulary; and adds definitions for excluded drug and health education quiz.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

[(9) Behavior Modification Health Coaching. A program in which health coaches assist members to make or maintain positive healthy behavior and lifestyle choices to help reduce and prevent health risk(s) and chronic disease(s).]

*[(10)]***(9)** Benefits. Health care services covered by the plan.

*[(11)]***(10)** Board. The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

*[(12)]***(11)** Cancellation of coverage. The ending of medical, dental, or vision coverage per a subscriber's voluntary request.

*[(13)]***(12)** Claims administrator. An organization or group responsible for processing claims and associated services for a health plan.

*[(14)]***(13)** Coinsurance. The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars ($100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars ($20). The health insurance or plan pays the rest of the allowed amount.

*[(15)]***(14)** Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

*[(16)]***(15)** Copayment. A fixed amount, for example, fifteen dollars ($15), the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.

*[(17)]***(16)** Date of service. Date medical services are received.

*[(18)]***(17)** Deductible. The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars ($1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollar ($1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

*[(19)]***(18)** Dependent. Spouse or child(ren) enrolled in the plan by a subscriber.

*[(20)]***(19)** Diabetes Education. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

[(21) Disease management. A multidisciplinary program designed to educate members with chronic diseases to manage their condition(s).]

*[(22)]***(20)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental medicine, including dental surgery;
(H) Doctor of dentistry; or
(I) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(23)]***(21)** Effective date. The date on which coverage takes effect.

*[(24)]***(22)** Eligible variable-hour employee. An employee of a state department or agency, whose employees are otherwise eligible for coverage, but is in a position not covered by a retirement system and the employer has notified the plan administrator that the employee has become benefit eligible due to having worked on average for thirty (30) or more hours per week during the time period measured.

*[(25)]***(23)** Eligibility date. The first day a member is qualified to enroll for coverage.

*[(26)]***(24)** Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.

*[(27)]***(25)** Emergency medical condition. The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(A) Placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) With respect to a pregnant woman who is having contractions—

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

*[(28)]***(26)** Emergency services. With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

*[(29)]***(27)** Employee. A benefit-eligible person employed by the state, including present and future retirees from state employment, who meet the plan eligibility requirements.

*[(30)]***(28)** Employer. The state department or agency that employs the eligible employee.

*[(31)]***(29)** Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance *[ab]*use disorder services, including behavioral health treatment—inpatient and outpatient and mental health/substance *[ab]*use disorder office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care;

(H) Laboratory services—lab and X-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

(30) Excluded drug. A drug the pharmacy benefit manager (PBM) does not pay for or cover unless an exception is approved by the PBM.

*[(32)]***(31)** Excluded services. Health care services that the member's health plan does not pay for or cover.

*[(33)]***(32)** Experimental/investigational/unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan—

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis; or

(C) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

*[(34)]***(33)** Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager **(PBM)** and covered by the plan administrator. **The PBM categorizes each formulary drug and formulary supply as preferred or non-preferred.**

*[(35)]***(34)** Foster parent. Any approved specialized foster parent as defined in section 210.543, RSMo, also referred to as Elevated Needs Level B, and licensed under Chapter 210, RSMo, who provides temporary foster care for children who have a documented history of presenting behaviors or diagnoses which render the child unable to effectively function outside of a highly structured setting, not in anticipation of adoption and not for children related to such Elevated Needs Level B foster parent.

*[(36)]***(35)** Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

*[(37)]***(36)** Health assessment (HA). An online questionnaire about a member's health and lifestyle habits required for participation in the *Strive for Wellness*® Partnership Incentive.

(37) Health Education Quiz. A series of questions administered by MCHCP designed to measure understanding of MCHCP benefits and/or general health knowledge.

[(52) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.]

*[(53)]***(52)** Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

*[(54)]***(53)** Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, *[copayments,]* balance-billed charges, or health care services the plan does not cover.

*[(55)]***(54)** Participant. Shall have the same meaning as the term member defined herein (see member, section (50)).

*[(56)]***(55)** Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(57)]***(56)** Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.

*[(58)]***(57)** Plan year. The period of January 1 through December 31.

*[(59)]***(58)** Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

*[(60)]***(59)** Premium. The monthly amount that must be paid for health insurance.

*[(61)]***(60)** Primary care provider (PCP). An internist, family/general practitioner, pediatrician, or physician assistant or nurse practitioner in any of the practice areas listed in this definition.

*[(62)]***(61)** Preauthorization. A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. The plan may require preauthorization for certain services before the member receives them, except in an emergency. Preauthorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request preauthorization.

*[(63)]***(62)** Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(22). Other providers include, but are not limited to:

(A) Audiologist (AUD or Ph.D.);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Chiropractor;

(F) Licensed Clinical Social Worker (LCSW);

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a Ph.D. or Master's Degree in Psychology or Counseling.

*[(64)]***(63)** Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(65)]***(64)** Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.

*[(66)]***(65)** Retiree. Notwithstanding any provision of law to the contrary, for the purposes of these regulations a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from a state-sponsored retirement system.

*[(67)]***(66)** Sound, natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound, natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

*[(68)]***(67)** Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(69)]***(68)** Specialty medications. High-cost drugs *[that]***, as determined by the pharmacy benefit manager and/or third party administrator, which** treat chronic **or** complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

*[(70)]***(69)** State. Missouri.

*[(71)]***(70)** Step therapy. Therapy designed to encourage use of therapeutically equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(72)]***(71)** Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the member and recover the money directly from the other insurer.

*[(73)]***(72)** Subscriber. The person who elects coverage under the plan.

*[(74)]***(73)** Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree.

*[(75)]***(74)** Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

*[(76)]***(75)** Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

*[(77)]***(76)** Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

*[(78)]***(77)** Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

*[(79)]***(78)** Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

*[(80)]***(79)** Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

*[(81)]***(80)** Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (12) and (13).

PURPOSE: This amendment clarifies requirements for members with Medicare and clarifies requirements for members with other health coverage.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(12) *[Medicare.*

(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(C)] Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. If Medicare coverage begins before turning age sixty-five (65) years, the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.

(13) Members are required to *[annually]* disclose to the claims administrator whether **or whether not** they have other health coverage and, if so, information about the coverage. A member may submit *[other coverage]* **this** information to the claims administrator by phone, fax, mail, or online. Dependent claims will *[not]* be *[processed until the information is received]* **denied if the disclosure is not made**. Once the information is received, claims will be *[processed]* **reprocessed** subject to all applicable rules.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending section (7).

PURPOSE: This amendment clarifies the Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree and survivor premium for members enrolled in the Medicare Prescription Drug Only Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(7) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree and survivor premium for members enrolled in the Medicare Prescription Drug Only Plan is based on either of the following:

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (7)(A) is compared to *[fifty-three percent (53%)]* **fifty-eight percent (58%)** of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (7)(A) or *[fifty-three percent*

[53%)] **fifty-eight percent (58%)** of the Medicare Prescription Drug Only Plan.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5) and adding a new section (15).

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) when provided at a network provider and adds requirements for members with Medicare.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(B) Nutritional counseling; *[and]*

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth*[.]*; **and**

(D) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges .The Missouri Consolidated Health Care Plan is amending section (5) and adding a new section (15).

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) when provided at a network provider and adds requirements for members with Medicare.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency

amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth*[.]*; **and**

(D) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is adding a new section (8), amending sections (17) and (19), and renumbering as necessary.

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) after the deductible is met, clarifies that a subscriber does not qualify for the HSA Plan if they are enrolled in Medicare, unless Medicare is secondary coverage to MCHCP, and clarifies requirements for members who become ineligible for the HSA Plan during the plan year.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(8) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

*[(8)]***(9)** Newborn's claims will be subject to deductible and coinsurance.

*[(9)]***(10)** Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

*[(10)]***(11)** Each subscriber will have access to payment information of the family unit.

*[(11)]***(12)** Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

*[(12)]***(13)** Usual, customary, and reasonable fee allowed—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

*[(13)]***(14)** Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

*[(14)]***(15)** For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

*[(15)]***(16)** Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*[(16)]***(17)** A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section *[(19)]* **(20)** of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare **(unless Medicare is secondary coverage to MCHCP)**;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-*[scope]***purpose health FSA**, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

*[(17)]***(18)** If a retiree subscriber and/or his/her dependent(s) becomes eligible for Medicare in the upcoming plan year then s/he may not enroll in the HSA Plan during open enrollment.

*[(18)]***(19)** If a subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber *[must]* **and/or his/her dependent(s) will be enrolled in the PPO 600 Plan. The subscriber may** enroll in a **different** non-HSA Plan within thirty-one (31) days of notice from MCHCP. *[If no plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan.]*

*[(19)]***(20)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*[(20)]***(21)** Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both a husband and wife are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars ($600) regardless of the number of HSAs or the number of children covered under the HSA Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar ($300) contribution to each spouse to total maximum six hundred dollars ($600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

Deposit	Subscriber Only	All other coverage levels
January	$300.00	$600.00
April (delayed contribution due to health care FSA grace period)	$300.00	$600.00
All others	A proration of $300	A proration of $600

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the

Code of State Regulations. *Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register***.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment clarifies the benefits for applied behavior analysis for autism, diabetes education, eye glasses and contact lenses following cataract surgery, office visits, and preventive services.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register***. *This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(3) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HSA Plan.

(E) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or
(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or
(II) Drugs when all of the following are met:
(a) History of allergy to a particular drug;
(b) There is no effective alternative drug; and
(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
(II) Food allergy;
(III) Hymenoptera venom allergy (stinging insects);
(IV) Inhalant allergy; or
(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;
(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;
(III) Thymoma; and
(IV) To predict allograft compatibility in the transplant setting;

M. Allergy *[R]***re***[-]*testing: routine allergy re*[-]*testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;
(II) Dust mite atopic dermatitis;
(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
(IV) Mold-induced allergic rhinitis;
(V) Perennial rhinitis;
(VI) Seasonal allergic rhinitis or conjunctivitis when one

(1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism *[is covered for children younger than age nineteen (19) years]*;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following non-implantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

6. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease; and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. *[Diabetic]* **Diabetes** Education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider.

15. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

16. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

17. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement *[immediately]* **within one (1) year** following cataract surgery;

18. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

19. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

20. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

21. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

22. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

23. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars ($1,000).

(II) Programmable: two thousand dollars ($2,000).

(III) Digital: two thousand five hundred dollars ($2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

24. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

25. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

26. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the

supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

27. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual (DSM)*. If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

28. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or *[anastamosis]* **anastomosis** status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

29. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

30. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home.

31. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for

which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

32. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

33. Office visit. Member encounter with a provider for health care, mental health, or substance *[ab]*use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

34. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

35. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

36. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fit**ted** with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing

activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

37. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and *[routine lab and X-ray]* **other** services ordered as part of the exam. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit**. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography)**;

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—*[One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema]* **no age limit**.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

38. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

39. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

40. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

41. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

42. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

43. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years**,** travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services

Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

44. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

45. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment removes the limitations upon gender reassignment services and associated expenses of transformation operations and self-inflicted injuries.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055.

[(X) Gender reassignment services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.]

*[(Y)]***(X)** Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

*[(Z)]***(Y)** Health and athletic club membership—including costs of enrollment.

*[(AA)]***(Z)** Hearing aid replacement batteries.

*[(BB)]***(AA)** Home births.

*[(CC)]***(BB)** Immunizations requested by third party.

*[(DD)]***(CC)** Infertility treatment beyond the covered services to diagnose the condition.

*[(EE)]***(DD)** Level of care, greater than is needed for the treatment of the illness or injury.

*[(FF)]***(EE)** Long-term care.

*[(GG)]***(FF)** Maxillofacial surgery.

*[(HH)]***(GG)** Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(II)]***(HH)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(JJ)]***(II)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(KK)]***(JJ)** Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

*[(LL)]***(KK)** Nocturnal enuresis alarm.

*[(MM)]***(LL)** Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance*[d]* by the PBM.

*[(NN)]***(MM)** Non-medically necessary services.

*[(OO)]***(NN)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(PP)]***(OO)** Non-reusable disposable supplies.

*[(QQ)]***(PP)** Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

*[(RR)]***(QQ)** Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(SS)]***(RR)** Physical and recreational fitness.

*[(TT)]***(SS)** Private-duty nursing.

*[(UU)]***(TT)** Routine foot care without the presence of systemic disease that affects lower extremities.

[(VV) Self-inflicted injuries—not covered unless related to a mental diagnosis.]

*[(WW)]***(UU)** Services obtained at a government facility if care is provided without charge.

*[(XX)]***(VV)** Sex therapy.

*[(YY)]***(WW)** Surrogacy—pregnancy coverage is limited to plan member.

*[(ZZ)]***(XX)** Telehealth site origination fees or costs for the provision of telehealth services are not covered.

*[(AAA)]***(YY)** Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

*[(BBB)]***(ZZ)** Travel expenses.

*[(CCC)]***(AAA)** Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment revises the amount thresholds in the initial coverage stage, coverage gap stage, and catastrophic coverage stage; and clarifies terminology regarding the categories of contraception covered at one hundred percent (100%).

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(1) The pharmacy benefit for Medicare primary members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non–Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and *[Medicare]* **Medicaid** Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[two thousand nine hundred sixty dollars ($2,960)]* **three thousand seven hundred dollars ($3,700)**, the member will pay the following copayments:

A. **Preferred Formulary** Generic *[Formulary]* Drugs: thirty-one- (31-) day supply has an eight dollar ($8) copayment; sixty- (60-) day supply has a sixteen dollar ($16) copayment; ninety- (90-) day supply at retail has a twenty-four dollar ($24) copayment; and a ninety- (90-) day supply through home delivery has a twenty dollar ($20) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a thirty-five dollar ($35) copayment; sixty- (60-) day supply has a seventy dollar ($70) copayment; ninety- (90-) day supply at retail has a one hundred five dollar ($105) copayment; and a ninety- (90-) day supply through home delivery has an eighty-seven dollar and fifty cent ($87.50) copayment; and

C. Non-preferred Formulary *[Brand]* Drugs **and approved excluded drugs**: thirty-one- (31-) day supply has a one hundred dollar ($100) copayment; sixty- (60-) day supply has a two hundred dollar ($200) copayment; ninety- (90-) day supply at retail has a three hundred dollar ($300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar ($250) copayment;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand three hundred ten dollars ($3,310)]* **three thousand seven hundred dollars ($3,700)** and remain below *[four thousand eight hundred fifty dollars ($4,850)]* **four thousand nine hundred fifty dollars ($4,950)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[four thousand eight hundred fifty dollars ($4,850)]* **four thousand nine hundred fifty dollars ($4,950)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[four thousand eight hundred fifty dollars ($4,850)]* **four thousand nine hundred fifty dollars ($4,950)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[two dollar and ninety-five cent ($2.95)]* **three dollar and thirty cent ($3.30)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or *[a seven dollar and forty cent ($7.40)]* **an eight dollar and twenty-five cent ($8.25)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage;

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs; and

6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.

(I) Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

1. Prescribed Vitamin D for all ages:

A. The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D_2 or D_3 per dose;

2. Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

3. Influenza vaccine and administration as recommend by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

4. *[Formulary]* **Preferred formulary** brand contraception and *[non-formulary]* **non-preferred** contraception when the provider determines a generic is not medically appropriate or a generic version is not available.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (4).

PURPOSE: This amendment clarifies copayment and coinsurance tiers, adds a diabetic drug copayment for members enrolled in a PPO plan and coinsurance for diabetic drugs for members enrolled in the HSA Plan, clarifies coverage of specialty drugs, adds one hundred percent (100%) coverage of prescribed preferred diabetic test strips, lancets, and preferred glucometer for members in a PPO plan, and one hundred percent (100%) coverage after deductible is met for prescribed preferred diabetic test strips, lancets, and preferred glucometer for members in the HSA plan, revises claims filing instructions, and clarifies language regarding the formulary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all*

interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO 300 and PPO 600.

1. Network:

A. *[Generic]* **Preferred formulary generic drug** copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. *[Brand]* **Preferred formulary brand drug** copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug** copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

*[D.]***E.** Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum; and

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy**, unless the prescription is identified by the PBM as emergent**. The first fill of a specialty prescription **identified to be emergent,** may be filled through a retail pharmacy *[if the prescription is identified by the PBM as emergent]*;

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) *[Generic]* **Preferred formulary generic drug** copayments: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) *[Brand]* **Preferred formulary brand drug** copayments: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug** copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

F. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

*[E.]***G.** Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

*[F.]***H.** The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

*[G.]***I.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

*[H.]***J.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum; and

*[I.]***K.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; *[and]*

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer*[.]***;**

(V) Prescribed preferred diabetic test strips and lancets; and

(VI) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—five thousand one hundred dollars ($5,100).

D. Family—ten thousand two hundred dollars ($10,200).

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. *[Generic]* **Preferred formulary generic drug**: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. *[Brand]* **Preferred formulary brand drug**: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug**: Forty percent (40%) coinsurance after deductible has been met *[for a drug not on the formulary]*;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met;

*[D.]***E.** Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM;

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy**, unless the prescription is identified by the PBM as emergent**. The first fill of a specialty prescription **identified to be emergent,** may be filled through a retail pharmacy *[if the prescription is identified by the PBM as emergent]*;

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

*[E.]***F.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer.

*[F.]***H.** If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. *[Generic]* **Preferred formulary generic drug**: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. *[Brand]* **Preferred formulary brand drug**: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31) day supply for a brand drug on the formulary.

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug**: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

(3) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. A member may request a claim form from the plan or the PBM. In order to file a claim, the member must—

(A) Complete the claim form **and follow its instructions**;

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions except diabetic supplies*[. If attaching a receipt or label, the receipt or label shall include:]***; and**

[1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply; and]

(4) Formulary. The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug*[. If this occurs, the generic copayment applies]*;

(C) A drug is determined to have a safety issue by the United States Food and Drug Administration (FDA). If this occurs, then the drug is no longer **covered** under the pharmacy benefit.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections

(10) and (14).

PURPOSE: This amendment clarifies requirements for members with Medicare and clarifies requirements for members with other health coverage.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(10) Medicare.

[(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(C) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.]

*[(D)]***(A)** Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. *[Claims will not be processed until the required information is provided.]* If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire. The member must *[submit]* **return** the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical *[plan]* **vendor**.

(B) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the Medicare Part D coverage gap.

(14) Members are required to *[annually]* disclose to the claims administrator whether they have other health coverage and, if so, information about the coverage. A member may submit other coverage information to the claims administrator by phone, fax, mail, or online. Dependent claims will *[not]* be *[processed]* **denied** until the information is received. Once the information is received, claims will be *[processed]* **reprocessed** subject to all applicable rules.

*AUTHORITY: section 103.059, RSMo 2000, and section 103.078, RSMo Supp. 2013. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RESCISSION

22 CSR 10-2.150 Disease Management Services Provisions and Limitations. This rule established the policy of the board of trustees in regards to the disease management services including the disease management program and the disease management rewards; and the method and timeframes in which the requirements of the disease management rewards must be completed.

PURPOSE: This rule is being rescinded due to disease management services being discontinued.

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This*

*emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Original rule filed Oct. 29, 2014, effective May 30, 2015. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (28), (32), (59), and (64), removing sections (20) and (47), adding a new section (29), and renumbering as necessary.

PURPOSE: This amendment revises the definitions of essential benefits, formulary, out-of-pocket maximum, public entity, and specialty medications; removes the definitions of disease management and non-formulary; and adds the definition for excluded drug.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

[(20) Disease management. A multidisciplinary program designed to educate members with chronic diseases to manage their condition(s).]

*[(21)]***(20)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental medicine, including dental surgery;
(H) Doctor of dentistry; or
(I) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(22)]***(21)** Effective date. The date on which coverage takes effect.

*[(23)]***(22)** Eligibility date. The first day a member is qualified to enroll for coverage.

*[(24)]***(23)** Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.

*[(25)]***(24)** Emergency medical condition. The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(A) Placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) With respect to a pregnant woman who is having contractions—

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

*[(26)]***(25)** Emergency services. With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and
(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

*[(27)]***(26)** Employee. A benefit-eligible person employed by a participating public entity, including present and future retirees from the participating public entity, who meet the plan eligibility requirements.

*[(28)]***(27)** Employer. The public entity that employs the eligible employee.

*[(29)]***(28)** Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance *[ab]*use disorder services, including behavioral health treatment—inpatient and outpatient and mental health/substance *[ab]*use disorder office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care;

(H) Laboratory services—lab and X-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

(29) Excluded drug. A drug the pharmacy benefit manager (PBM) does not pay for or cover unless an exception is approved by the PBM.

(32) Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager **(PBM)** and covered by the plan administrator. **The PBM categorizes each formulary drug and formulary supply as preferred or non-preferred.**

[(47) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.]

*[(48)]***(47)** Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

*[(49)]***(48)** Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, *[copayments,]* balance-billed charges, or health care services the plan does not cover.

*[(50)]***(49)** Participant. Shall have the same meaning as the term member defined herein (see member, section (45)).

*[(51)]***(50)** Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(52)]***(51)** Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.

*[(53)]***(52)** Plan year. The period of January 1 through December 31.

*[(54)]***(53)** Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

*[(55)]***(54)** Premium. The monthly amount that must be paid for health insurance.

*[(56)]***(55)** Primary care provider (PCP). An internist, family/general practitioner, pediatrician, or physician assistant or nurse practitioner in any of the practice areas listed in this definition.

*[(57)]***(56)** Preauthorization. A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. The plan may require preauthorization for certain services before the member receives them, except in an emergency. Preauthorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request preauthorization.

*[(58)]***(57)** Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(21). Other providers include, but are not limited to:

(A) Audiologist (AUD or PhD);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Chiropractor;

(F) Licensed Clinical Social Worker (LCSW);

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

*[(59)]***(58)** Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(60)]***(59)** Public entity. A *[state-sponsored institution of higher learning,]* political subdivision*[,]* or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.

*[(61)]***(60)** Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.

*[(62)]***(61)** Retiree. Notwithstanding any provision of law to the contrary, for the purposes of these regulations, a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from an entity-sponsored retirement system.

*[(63)]***(62)** Sound, natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound, natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

*[(64)]***(63)** Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(65)]***(64)** Specialty medications. High-cost drugs *[that]***, as determined by the pharmacy benefit manager and/or third party administrator which** treat chronic **or** complex conditions such as

hepatitis C, multiple sclerosis, and rheumatoid arthritis.

*[(66)]***(65)** State. Missouri.

*[(67)]***(66)** Step therapy. Therapy designed to encourage use of therapeutically equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(68)]***(67)** Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the member and recover the money directly from the other insurer.

*[(69)]***(68)** Subscriber. The person who elects coverage under the plan.

*[(70)]***(69)** Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree of a public entity with a retirement system.

*[(71)]***(70)** Terminated vested subscriber. A previous active employee eligible for a future retirement benefit through a public entity's retirement system.

*[(72)]***(71)** Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

*[(73)]***(72)** Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

*[(74)]***(73)** Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

*[(75)]***(74)** Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits through a public entity's retirement system.

*[(76)]***(75)** Waiting/probationary periods. The length of time the employer requires an employee to be employed before he or she is eligible for health insurance coverage. Public entities may set different waiting/probationary periods for different employee classifications (full-time vs. part-time).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (12) and (13).

PURPOSE: This amendment clarifies requirements for members with Medicare and clarifies requirements for members with other health coverage.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(12) *[Medicare.*

(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.

(C)] Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.

(13) Members are required to *[annually]* disclose to the claims administrator whether **or whether not** they have other health coverage and, if so, information about the coverage. A member may submit *[other coverage]* **this** information to the claims administrator

by phone, fax, mail, or online. Dependent claims will *[not]* be *[processed until the information is received]* **denied if the disclosure is not made**. Once the information is received, claims will be *[processed]* **reprocessed** subject to all applicable rules.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5) and adding a new section (14).

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) when provided at a network provider and adds requirements for members with Medicare.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth*[.]***; and**

(D) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider.

(14) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(D) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit(s) must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the Medicare Part D coverage gap.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is adding a new section (8), amending section (15), and renumbering as necessary.

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) after the deductible is met and clarifies that a subscriber does not qualify for the HSA Plan if they are enrolled in Medicare, unless Medicare is secondary coverage to MCHCP.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the

Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(8) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

*[(8)]***(9)** Newborn's claims will be subject to deductible and coinsurance.

*[(9)]***(10)** Each subscriber will have access to payment information of the family unit.

*[(10)]***(11)** Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

*[(11)]***(12)** Usual, customary, and reasonable fee allowed—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor. Members may be held liable for the amount of the fee above the allowed amount.

*[(12)]***(13)** Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

*[(13)]***(14)** For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

*[(14)]***(15)** A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section *[(15)]* **(16)** of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare **(unless Medicare is secondary coverage to MCHCP)**;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-*[scope]***purpose health FSA**, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

*[(15)]***(16)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

*[(16)]***(17)** Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (5) and adding a new section (14)

PURPOSE: This amendment adds diabetes education visits to the services paid at one hundred percent (100%) when provided at a network provider and adds requirements for members with Medicare.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the

first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth*[.]*; **and**

(D) Four (4) diabetes education visits with a certified diabetes educator when ordered by a provider.

(14) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(D) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit(s) must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the Medicare Part D coverage gap.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (3).

PURPOSE: This amendment clarifies the benefits for applied behavior analysis for autism, diabetes education, eye glasses and contact lenses following cataract surgery, office visits, and preventive services.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(3) Covered Charges Applicable to the PPO 600 Plan, PPO 1000, and HSA Plan.

(E) Plan benefits for the PPO 600 Plan, PPO 1000, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions

occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy *[R]*re*[-]*testing: routine allergy re*[-]*testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism *[is covered for children younger than age nineteen (19) years]*;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has

reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following non-implantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.); or

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

6. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that maybe relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation, or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe-to-profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

13. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury;

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease; and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequelae; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. *[Diabetic]* **Diabetes** Education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

15. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

16. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

17. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement *[immediately]* **within one (1) year** following cataract surgery;

18. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

19. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

20. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

21. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

22. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

23. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A comprehensive medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1)

hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars ($1,000).

(II) Programmable: two thousand dollars ($2,000).

(III) Digital: two thousand five hundred dollars ($2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

24. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

25. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by, or under the supervision of, a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by, or under the supervision of, a licensed therapist;

E. Medical supplies, drugs or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

26. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by, or under the supervision of, a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

27. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time inpatient basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility, and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

28. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or *[anastamosis]* **anastomosis** status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

29. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

30. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

31. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

32. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

33. Office visit. Member encounter with a provider for health care, mental health, or substance *[ab]*use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

34. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

35. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequelae;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviations from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

36. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering, or expected to interfere, significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of

the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissue(s);

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue(s); or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissue(s); or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue(s).

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

37. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and *[routine lab and X-ray]* **other** services ordered as part of the exam. For benefits to be covered as preventive, *[including X-rays and lab services,]* they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit**. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography**;

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—*[One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema]* **no age limit**.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

38. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

39. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or

less than twenty milliliters per kilogram per minute (20 m**[/]/L**/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

40. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

41. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

42. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver-provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

43. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years**,** travel and lodging is covered for both parent(s). The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

44. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

45. Vision. One (1) routine exam and refractions is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan Limitations. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment removes the limitations upon gender reassignment services and associated expenses of transformation operations and self-inflicted injuries.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The*

MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise, and then only to the extent expressly provided herein or in 22 CSR 10-3.057.

[(X) Gender reassignment services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.]

[(Y)](X) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

*[(Z)]***(Y)** Health and athletic club membership—including costs of enrollment.

*[(AA)]***(Z)** Hearing aid replacement batteries.

*[(BB)]***(AA)** Home births.

[(CC)](**BB)** Immunizations requested by third party.

*[(DD)]***(CC)** Infertility treatment beyond the covered services to diagnose the condition.

*[(EE)]***(DD)** Level of care, greater than is needed for the treatment of the illness or injury.

*[(FF)]***(EE)** Long-term care.

*[(GG)]***(FF)** Maxillofacial surgery.

*[(HH)]***(GG)** Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

*[(II)]***(HH)** Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

*[(JJ)]***(II)** Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

*[(KK)]***(JJ)** Never events—a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

*[(LL)]***(KK)** Nocturnal enuresis alarm.

*[(MM)]***(LL)** Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance*[d]* by the PBM.

*[(NN)]***(MM)** Non-medically necessary services.

*[(OO)]***(NN)** Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

*[(PP)]***(OO)** Non-reusable disposable supplies.

*[(QQ)]***(PP)** Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, filling out paperwork, or late payments.

*[(RR)]***(QQ)** Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, nonsedating antihistamines, unless otherwise covered as a preventive service.

*[(SS)]***(RR)** Physical and recreational fitness.

*[(TT)]***(SS)** Private-duty nursing.

*[(UU)]***(TT)** Routine foot care without the presence of systemic disease that affects lower extremities.

[(VV) Self-inflicted injuries—not covered unless related to a mental diagnosis.]

*[(WW)]***(UU)** Services obtained at a government facility if care is provided without charge.

*[(XX)]***(VV)** Sex therapy.

*[(YY)]***(WW)** Surrogacy—pregnancy coverage is limited to plan member.

*[(ZZ)]***(XX)** Telehealth site origination fees or costs for the provision of telehealth services are not covered.

*[(AAA)]***(YY)** Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs);

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance;

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

*[(BBB)]***(ZZ)** Travel expenses.

*[(CCC)]***(AAA)** Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (4).

PURPOSE: This amendment clarifies copayment and coinsurance tiers, adds a diabetic drug copayment for members enrolled in a PPO plan and coinsurance for diabetic drugs for members enrolled in the HSA Plan, clarifies coverage of specialty drugs, adds one hundred percent (100%) coverage of prescribed preferred diabetic test strips, lancets, and preferred glucometer for members in a PPO plan, and one hundred percent (100%) coverage after deductible is met for prescribed preferred diabetic test strips, lancets, and preferred glucometer for members in the HSA plan, revises claims filing instructions, and clarifies language regarding the formulary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO 600 and PPO 1000 Prescription Drug Coverage.

1. Network.

A. *[Generic]* **Preferred formulary generic drug** copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. *[Brand]* **Preferred formulary brand drug** copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug** copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment.

*[D.]***E.** Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescription(s) will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy**, unless the prescription is identified by the PBM as emergent**. The first fill of a specialty prescription may be filled through a retail pharmacy *[if the prescription is identified by the PBM as emergent]*.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) *[Generic]* **Preferred formulary generic drug** copayments: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic

drug on the formulary;

(b) *[Brand]* **Preferred formulary brand drug** copayments: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug** copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary.

F. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment.

*[E.]***G.** Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

*[F.]***H.** The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

*[G.]***I.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

*[H.]***J.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum.

*[I.]***K.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; *[and]*

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer*[.]***;**

(V) Prescribed preferred diabetic test strips and lancets; and

(VI) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—five thousand one hundred dollars ($5,100).

D. Family—ten thousand two hundred dollars ($10,200).

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. *[Generic]* **Preferred formulary generic drug**: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. *[Brand]* **Preferred formulary brand drug**: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug**: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met.

*[D.]***E.** Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to **a** thirty-one- (31-) day*[s.]* **supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.**

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

*[E.]***F.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed Vitamin D for all ages.

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; *[and]*

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer.

*[F.]***H.** If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. *[Generic]* **Preferred formulary generic drug**: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. *[Brand]* **Preferred formulary brand drug**: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. *[Non-formulary]* **Non-preferred formulary drug and approved excluded drug**: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

(3) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. A member may request a claim form from the plan or the PBM. In order to file a claim, the member must—

(A) Complete the claim form **and follow its instructions**;

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions except diabetic supplies*[. If attaching a receipt or label, the receipt or label shall include:]***; and**

[1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply; and]

(4) Formulary—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug*[. If this occurs, the generic copayment applies]*;

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RESCISSION

22 CSR 10-3.150 Disease Management Services Provisions and Limitations. This rule is being rescinded due to disease management services being discontinued.

PURPOSE: This rule established the policy of the board of trustees in regards to the disease management services including the disease management program and the disease management rewards; and the method and timeframes in which the requirements of the disease management rewards must be completed.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2017, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 28, 2016, becomes effective January 1, 2017, and expires June 29, 2017.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Original rule filed Oct. 29, 2014, effective May 30, 2015. Emergency amendment filed Oct. 28, 2015, effective Jan. 1, 2016, expired June 28, 2016. Amended: Filed Oct. 28, 2015, effective May 30, 2016. Emergency rescission filed Oct. 28, 2016, effective Jan. 1, 2017, expires June 29, 2017. A proposed rescission covering this same material is published in this issue of the ***Missouri Register****.*