Schedule C
HSA Contribution Benefit

Unless otherwise specified, terms capitalized in this Schedule C shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

C.1 HSA Tax Advantages

An Employee may elect to participate in the HSA Contribution Benefit by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's Health Savings Account (HSA) established and maintained outside the Plan by a trustee/custodian to which the Employer can forward Contributions to be deposited. This funding feature constitutes the HSA Contribution Benefit.

As described more fully herein, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

C.2 Establishing an HSA

For administrative convenience, the Employer may chose to make Contributions for Employees to HSAs established at a bank selected by the Employer or limit the number of HSA providers to whom it will forward Contributions-such a list is not an endorsement of any HSA provider. The selected bank will be an authorized HSA trustee. The forms necessary to establish an HSA at the selected bank will be provided to Participants. Participants are responsible for managing their own HSA, including choosing how HSA funds are invested and following the rules of the selected bank and the IRS. Once the Employer Contributions have been deposited in a Participant's HSA Contribution Benefit, the Participant has a non-forfeitable interest in the funds and is free to request a distribution of the funds or to move them to another HSA provider, to the extent permitted by law.

The HSA Contribution Benefit cannot be elected with the Health FSA. In addition, a Participant who has an election for the Health FSA that is in effect on the last day of a Plan Year cannot elect the HSA Contribution Benefit for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA is $0 as of the last day of the Plan Year. For this purpose, a Participant's Health FSA balance is determined on a cash basis -- that is, without regard to claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

C.3 Certification of HSA Contribution Benefit Eligibility

To be eligible for the HSA Contribution Benefit, an HSA Employee must certify to the Employer that he or she is eligible for an HSA contribution and does not have any non-HDHP coverage. A married Participant must also certify that his or her Spouse does not have any non-HDHP coverage. A Participant is required to notify the Employer immediately if there are any changes in the information contained in the certification. Failure to provide accurate and updated information could cause the HSA Contribution Benefit to be included in a Participant's gross income and may also be subject to excise tax.

C.4 Maximum Contribution

The annual Contribution for a Participant's HSA Contribution Benefit is equal to the annual Benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's HDHP coverage option for the calendar year in which the Contribution is made (for calendar year 2011, $3,050 for self-coverage or $6,150 for family coverage).

Participants age 55 or older may make an additional catch-up Contribution of $1,000 per year.

In addition, the maximum annual Contribution shall be:

- **Reduced by any matching or other Employer Contribution made on the Participant's behalf; and**
- **Prorated for the number of months in which the Participant is an HSA Eligible Individual.**

C.5 Recording Contributions for HSA

The Plan Administrator will maintain records to keep track of Contributions an Employee makes via pre-tax Salary Reductions to his or her HSA, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

C.6 Distributions from HSA Contribution Benefit

Distribution from an HSA Contribution Benefit will be tax-free if the distribution is for expenses incurred for a Participant's health care as defined in IRC §213(d) or the health care of a Participant's legal Spouse or tax Dependents. Expenses must have been incurred after the establishment of the HSA Contribution Benefit to be tax-free. HSA Contribution Benefit distributions used to pay insurance premiums will not be tax-free unless they are used for COBRA coverage, qualified long-term care insurance, health insurance maintained while the individual is receiving unemployment compensation under federal or state law, or health insurance for an individual age 65 or over, other than a Medicare supplemental policy.

C.7 Tax Treatment of HSA Contributions and Distributions

The tax treatment of the HSA is governed by Code §223.

C.8 Reporting Issues

Each Participant will be responsible for reporting Contributions made to his or her HSA Contribution Benefit and for reporting distributions from the HSA. A Participant is also responsible for reporting whether or not HSA distributions were used for qualified health expenses or whether the distributions were taxable. A Participant should maintain records sufficient to demonstrate whether or not distributions were taxable.

C.9 Voluntary Participation

Participation in the HSA Contribution Benefit is entirely voluntary and may be terminated at any time by notifying the Employer. Although the Employer expects to continue this HSA Contribution Benefit indefinitely, it has the right to amend or terminate HSA Contribution Benefit at any time and for any reason. It is also possible that changes to the program will be necessary or advisable as a result of future changes in state or federal tax laws.

C.10 HSA Not Intended to be an ERISA Plan

The HSA Contribution Benefit under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and Benefits will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible health expenses" as set forth in Code §223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

Schedule D
Dependent Care Assistance Program

Unless otherwise specified, terms capitalized in this Schedule D shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

D.1 Benefits

An Employee can elect to participate in the DCAP to receive Benefits in the form of reimbursements for Dependent Care Expenses. If elected, the Benefit Option will be funded by the Participant on a pre-tax Salary Reduction basis. Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section above, such election is irrevocable for the duration of the Period of Coverage to which it relates.

D.2 Benefit Contributions

The annual Contribution for a Participant's DCAP Benefits is equal to the annual Benefit amount elected by the Participant, subject to the Maximum Benefits paragraph below.

D.3 Eligible Dependent Care Expenses

Under the DCAP, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred. A Dependent Care Expense is "incurred" at the time the Qualifying Dependent Care Service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.**

- **Dependent Care Expenses. Dependent Care Expenses means expenses that are considered to be:**

  - **Employment-related expenses under Code §21(b)(2) relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse; and**

  - **Expenses for incidental household services, if incurred by the Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other Plan.**

  If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Schedule.

- **Qualifying Individual. A Qualifying Individual is:**

  - **A tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1);**

- A tax dependent of the Participant as defined in Code §152, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

- A Participant's Spouse, as defined in Code §152, who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

In the case of divorced or separated parents, a child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code §152(e).

- Qualifying Dependent Care Services. Qualifying Dependent Care Services means services that both:

  - Relate to the care of a Qualifying Individual that enable the Participant and Spouse to remain gainfully employed after the date of participation in the DCAP and during the Period of Coverage; and

  - Are performed:

    - In the Participant's home; or

    - Outside the Participant's home for:

      - The care of a Participant's Dependent who is under age 13; or

      - The care of any other Qualifying Individual who regularly spends at least 8 hours per day in the Participant's household.

        In addition, if the expenses are incurred for services provided by a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services, then the facility must comply with all applicable state and local laws and regulations.

- Exclusions. Dependent Care Expenses do not include amounts paid to or for:

  - An individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or Participant's Spouse;

  - A Participant's Spouse;

  - A Participant's child, as defined in Code §152(f)(l), who is under 19 years of age at the end of the year in which the expenses were incurred; and

  - A Participant's Spouse's child, as defined in Code §152 (a)(i), who is under 19 years of age at the end of the year in which the expenses were incurred.

D.4 Maximum Benefit

- **Maximum Reimbursement Available and Statutory Limits. The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP less amounts debited to the Participant's DCAP pursuant to the Maximum Contribution paragraph below.**

  Payment shall be made to the Participant as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section have been satisfied.

  No reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the year to date amount of Participant Contributions to the DCAP for the Period of Coverage or applicable statutory limit.

- **Maximum Dollar Limit. The maximum dollar limit for a Participant is the smallest of the following amounts:**

  - **The Participant's Earned Income for the calendar year;**
  - **The Earned Income for the calendar year of the Participant's Spouse who:**
    - **Is not employed during a month in which the Participant incurs a Dependent Care Expense; and**
    - **Is either physically or mentally incapable of self-care or a full-time Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or**
  - **$5,000 for the calendar year or the maximum allowed under federal regulations, if:**
    - **The Participant is married and files a joint federal income tax return; or**
    - **The Participant is married, files a separate federal income tax return, and meets the following conditions:**
      - **The Participant maintains as his or her home a household that constitutes, for more than half of the taxable year, the principal abode of a Qualifying Individual;**
      - **The Participant furnishes over half of the cost of maintaining such household during the taxable year; and**
      - **During the last six months of the taxable year, the Participant's Spouse is not a member of such household; or**

- The Participant is single or is the head of the household for federal income tax purposes.

- $2,500 for the calendar year, or the maximum allowed under federal regulation, if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

- Changes. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document.

- No Proration. If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.

- Effect on Maximum Benefits If Election Change Permitted. Any change in an election affecting annual Contributions to the DCAP component will also change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change effective date. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:

  - The aggregate Contribution for the period prior to such election change; to

  - The total Contribution for the remainder of such Period of Coverage to the DCAP; reduced by

  - All reimbursements made during the entire Period of Coverage.

D.5 Establishment of Account

The Plan Administrator will establish and maintain a DCAP with respect to each Participant who has elected to participate in the DCAP, but will not create a separate fund or otherwise segregate assets for this purpose. The account so established will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- Crediting of Accounts. A Participant's DCAP will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.

- Debiting of Accounts. A Participant's DCAP will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

- Available Amount is Based on Credited Amount. The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP, less any prior reimbursements. A Participant's DCAP may not have a negative balance during a Period of Coverage.

D.6 Unused Year End Balance

- Use It or Lose It Rule. If any balance remains in the Participant's DCAP after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during the subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. Claims must be submitted on or before April 15th of the year immediately following the close of the plan year in which the expenses were incurred.

- Use of Forfeiture. All forfeitures shall be used by the Plan in the following ways:

  - To offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participant through Salary Reduction;

  - To reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and

  - To provide increased Benefits or Compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, and consistent with applicable regulations.

- Unclaimed Benefits. Any DCAP Benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be applied as described above.

D.7 Reimbursement Procedure

- Timing. Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses or the Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.

- Claims Substantiation. A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by completing, signing, and returning an application to the Plan Administrator by no later than the date set by the Plan Administrator each year, setting forth:

  - The person or persons on whose behalf Dependent Care Expenses have been incurred;

  - The nature and date of the expenses incurred;

  - The amount of the requested reimbursement;

  - The name of the person, organization or entity to whom the expense was or is to be paid;

- A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source;
- The Participant's certification that he or she has no reason to believe that the reimbursement refunded, added to other reimbursements to date will exceed the limit herein; and
- Other such details about the expenses that may be requested by the Plan Administrator.

The Participant shall include bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request.

- Claims Denied. For appeals of claims that are denied, see the Appeals Procedure in the Plan Document.

D.8 Reimbursements After Termination

If a Participant's employment terminates, the Participant may submit for reimbursement Dependent Care Expenses incurred after the date of termination up to the amount of the Participant's remaining DCAP Benefits.

D.9 DCAP Participant vs. Claiming the Dependent Care Tax Credit

Employees often have the choice between participating in their employer's DCAP on a Salary Reduction basis or taking a Dependent Care Tax Credit under Code §21. Employees cannot take advantage of both tax benefit options. Employees with questions regarding which option is best should consult with an accountant.

*AUTHORITY: section 33.103, RSMo Supp. [2007] **2010**. Original rule filed March 15, 1988, effective June 1, 1988. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 21, 2010, effective Jan. 1, 2011, expires June 29, 2011. 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 deleting sections (3), (19), (26), (33), (37), (44), (48), (51), (55), (56), (63), (65), (70), (72), (79), (93)–(95), (97), (100), (115), (125), and (129); amending sections (5), (9), (12), (17), (21), (25), (30), (34), (35), (37), (38), (42), (45), (47)–(49), (51), (52), (55), (68), (75)–(77), (79), (82), (88), (89), (91), (92), (94), (95), (97), (99), (101), (103)–(105), (108), (110), (112)–(114), (116), (117), (119), (123), and (128); adding sections (2), (7), (8), (14), (15), (29), (31), (33), (40), (41), (44), (53), (56), (67), (69), (70), (73), (96), (125), (130), and (132)–(134); and renumbering as necessary.

PURPOSE: This amendment changes policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. 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 MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This 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. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(2) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

*[(2)]***(3)** Administrative appeal. A written request submitted by or on behalf of a member involving Missouri Consolidated Health Care Plan (MCHCP) administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

[(3) Administrative guidelines. Instructive interpretation of the plan document developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.]

(5) Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible*[,]* **and** coinsurance*[, or table of allowance included in the program]* **amounts**.

(7) Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

(8) Assignment. When a doctor agrees to accept Medicare's fee as full payment.

*[(7)]***(9)** Benefit period. The three hundred sixty-five (365) days immediately *[following the first date of like services]* **after the first date of services to treat a given condition**.

*[(8)]***(10)** Benefits. Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

*[(9)]***(11)** Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

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

*[(11)]***(13)** Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

(14) Cancellation of Coverage. The voluntary cancellation of medical, dental, or vision coverage per a subscriber's request.

(15) Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

*[(12)]***(16)** Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(13)]***(17)** Claims administrator. An organization or group responsible for the processing of claims and associated services for *[the plan's self-insured benefit programs, including but not limited*

to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans] **a health plan**.

*[(14)]***(18)** Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

*[(15)]***(19)** Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses**,** such as deductible or coinsurance.

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

*[(17)]***(21)** Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." *[CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.]*

*[(18)]***(22)** Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

[(19) Copay plan. A set of benefits similar to a health maintenance organization option.]

*[(20)]***(23)** Copayment. A set dollar amount that the covered individual must pay for specific services.

*[(21)]***(24)** Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.

*[(22)]***(25)** Covered benefits and charges. *[A schedule of covered services and charges payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.]* **Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.**

*[(23)]***(26)** Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living*[. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services]* that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.

*[(24)]***(27)** Date of service. Date medical services are received or performed.

*[(25)]***(28)** Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

[(26) Dependent-only participation. Participation of certain survivors of subscribers. Dependent participation may be further defined to include the deceased subscriber's:
(A) Spouse only;
(B) Child(ren) only; or
(C) Spouse and child(ren).]

(29) Dependent child. Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:
(A) Stepchild;
(B) Foster child for whom the employee is responsible for health care;
(C) Grandchild for whom the employee has legal guardianship or legal custody and is responsible for providing health care; and
(D) Other child for whom the employee is the court-ordered legal guardian responsible for providing health care.
1. Except for a disabled child as described in 22 CSR 10-2.010(89), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six (26)).

*[(27)]***(30)** Dependents. The lawful spouse of the employee, the employee's *[unemancipated]* child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom *[application]* **enrollment** has been made and has been accepted for participation in the plan.

(31) Diagnostic. Describes a procedure to determine whether a person has a particular illness.

*[(28)]***(32)** Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

(33) Disease management. A program offered to non-Medicare members to help manage certain chronic diseases.

*[(29)]***(34)** Disposable supplies. *[Medical s]***S**upplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

*[(30)]***(35)** 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) Psychiatrist;
*[(F)]***(G)** Psychologist;
*[(G)]***(H)** Doctor of **dental medicine, including** dental surgery; *[or]*
(I) Doctor of dentistry; or
*[(H)]***(J)** 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.

*[(31)]***(36)** Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

*[(32)]***(37)** Eligibility date. *[Refer to]* **As described in** 22 CSR 10-2.020**.** *[for effective date provisions.*
(A) Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.
(B) Employees transferred from a state department with coverage under another medical care plan into a state

department covered by this plan and their eligible dependents who were covered by the other medical care plan are eligible for participation immediately.

(C) Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.

(D) Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation or at the employee's choice, on the first day of the month following the employee's date of rehire.]

[(33) Emancipated child(ren). A child(ren) who is:

(A) Employed on a full-time basis;

(B) Eligible for group health benefits in his/her own behalf;

(C) Maintaining a residence separate from his/her parents or guardian, except for full-time students in an accredited school or institution of higher learning; or

(D) Married.]

*[(34)]***(38)** Emergency **medical condition**. *[Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:]* **A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—**

(A) Conditions 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) Situations when the health of a pregnant woman or her unborn child are threatened.

*[(35)]***(39)** Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

(40) 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 assure, 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.

(41) Employee. A person employed by the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by law.

*[(36)]***(42)** Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is *[not]* eligible as a dependent **up to the age of twenty-six (26)**, except as noted in 22 CSR 10-2.020(1)(A)3. *[Dependent participation may be further defined to include the participating employee's:*

(A) Spouse only;

(B) Child(ren) only; or

(C) Spouse and child(ren).]

[(37) Employees. Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law.]

*[(38)]***(43)** Employer. The state department or agency that employs the eligible employee as defined above.

(44) 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 abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency 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/palliative services;

(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.

*[(39)]***(45)** Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board **of trustees**.

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

(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 to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) 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.

*[(41)]***(47)** First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first *[eligible]* **eligibility** period is the first thirty-one (31) days from the date *[the dependent meets the eligibility requirements for coverage under the plan]* **of the life event**.

*[(42)]***(48)** Formulary. A list of drugs covered by the pharmacy *[program claims administrator]* **benefit manager** and as allowed by the plan administrator.

*[(43)]***(49)** 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.]* **There are two (2) types of generic drugs, a therapeutically equivalent generic and a chemically equivalent generic, as defined below.**

(A) Therapeutically equivalent generic drugs are drugs with active ingredients that are similar at the clinical level.

(B) Chemically equivalent generic drugs are drugs with active ingredients that are identical at the molecular level. The brand-name drug lost its patent and the generic is available for the exact drug.

[(44) Grievance. A written complaint submitted by or on behalf of a member regarding either:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling, or reimbursement for health care services.]

*[(45)]***(50)** Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

*[(46)]***(51)** Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference *[will be made]* **is** available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook (*[January 1, 2010]* **January 10, 2011**) **or online at www.mchcp.org**. It does not include any later amendments or additions.

*[(47)]***(52)** Health assessment **(HA)**. A questionnaire about a member's health and lifestyle habits *[which qualifies the member]* **required** for participation in the *[Lifestyle Ladder program to earn the incentive premium]* **wellness program**.

(53) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.

[(48) Health maintenance organization (HMO). A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment.]

*[(49)]***(54)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

*[(50)]***(55)** High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

[(51) Home health agency. An agency certified by Medicare and the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.]

(56) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.

*[(52)]***(57)** Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.

*[(53)]***(58)** Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

*[(54)]***(59)** Hospital.

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of *[(54)(A)]* **subsection (59)(A)** above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.

[(55) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.]

[(56) Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended

by a physician and approved by the claims administrator or the plan administrator.]

*[(57)]***(60)** Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

*[(58)]***(61)** Incident. A definite and separate occurrence of a condition.

*[(59)]***(62)** Infertility. Any medical condition causing the inability or diminished ability to reproduce.

*[(60)]***(63)** Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

*[(61)]***(64)** Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

*[(62)]***(65)** Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.

[(63) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.]

*[(64)]***(66)** Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

(67) Lifestyle Ladder. MCHCP's wellness program.

[(65) Lifetime. The period of time a member or the member's eligible dependents participate in the plan.]

*[(66)]***(68)** Lifetime maximum. The *[maximum]* amount payable by a medical plan during a covered member's life **for specific nonessential benefits**.

(69) MCHCPid. An individual MCHCP member identifier used for member verification and validation.

(70) myMCHCP. A secure MCHCP member website that includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites.

*[(67)]***(71)** Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.

*[(68)]***(72)** Medically necessary. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion*[:]*—

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

(73) Medicare approved amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or provider.

*[(69)]***(74)** Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

[(70) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.]

*[(71)]***(75)** Network provider. A physician, hospital, pharmacy, *[etc.,]* **or other health provider** that is contracted with the plan **or its designee**.

[(72) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.]

*[(73)]***(76)** Non-formulary. A drug not contained on the pharmacy *[program's formulary]* **benefit manager's** list *[but may be covered under the terms and conditions of the plan]* **of covered drugs**.

*[(74)]***(77)** Non-network provider or non-participating provider. A*[ny]* physician, hospital, pharmacy, *[etc.,]* **or other health provider** that does not have a contract with the plan **or its designee**.

*[(75)]***(78)** Nurse. A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

*[(76)]***(79)** Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients *[convalescing]* **recovering** from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations *[which]* **that** are recognized under Medicare.

*[(77)]***(80)** Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

*[(78)]***(81)** Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

[(79) Out-of-network. Providers that do not participate in the member's health or pharmacy plan.]

*[(80)]***(82)** Out-of-pocket maximum. *[The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.]* **The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays**

one hundred percent (100%) for covered services for the rest of the plan year.

*[(81)]***(83)** Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

*[(82)]***(84)** Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

*[(83)]***(85)** Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and *[impeccable]* assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

*[(84)]***(86)** Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; *[psychiatric]* nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions *[for therapeutic purposes]*.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

*[(85)]***(87)** Participant. Any employee or dependent accepted for membership in the plan.

*[(86)]***(88)** Pharmacy benefit manager (PBM). *[Acts as a link between the parties involved in the delivery of prescription drugs to health plan members.]* The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

*[(87)]***(89)** Physically or mentally disabled. *[The inability of a person]* **A person's inability** to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

*[(88)]***(90)** Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice**,** as licensed under section 334.021, RSMo.

*[(89)]***(91)** 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.

*[(90)]***(92)** Plan administrator. The **board of** trustees of the Missouri Consolidated Health Care Plan*[. As such, the board]***, 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.

*[(91)]***(93)** Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

*[(92)]***(94)** Plan year. *[Same as]* **The** calendar year **beginning January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year**.

[(93) Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.]

[(94) Pre-certification. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).]

[(95) Pre-existing condition. A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.]

*[(96)]***(95)** Preferred provider organization (PPO). An arrangement with providers where**by** discounted rates are given to **plan** members *[of the plan who, in turn, are offered a financial incentive to use these providers]*. **Benefits are paid at a higher level when network providers are used.**

[(97) Prevailing fee. The fee charged by the majority of dentists.]

(96) Preventive service. A procedure intended for avoidance or early detection of an illness.

*[(98)]***(97)** Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with *[and been approved by]* a medical plan.

*[(99)]***(98)** Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

[(100) Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the plan.]

*[(101)]***(99)** Private duty nursing. *[Private duty nursing services, n]***N**ursing care on a full-time basis in the member's home*[,]* or home health aides.

*[(102)]***(100)** Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

*[(103)]***(101)** Proof of **prior group** insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

*[(104)]***(102)** Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and

(C) List of dependents covered.

*[(105)]***(103)** Prostheses. An artificial extension that replaces a missing part of the body*[. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital)]* or *[to]* supplement**s** defective parts.

*[(106)]***(104)** Protected health information **(PHI)**. Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(107)]***(105)** Provider. *[Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.]* **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(35). 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 their license in the state in which they practice 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) Licensed Clinical Social Worker;

(F) Licensed Professional Counselor (LPC);

(G) Licensed Psychologist (LP);

(H) Nurse Practitioner (NP);

(I) Physicians Assistant (PA);

(J) Qualified Occupational Therapist;

(K) Qualified Physical Therapist;

(L) Qualified Speech Therapist;

(M) Registered Nurse Anesthetist (CRNA);

(N) Registered Nurse Practitioner (ARNP); or

(O) Therapist with a PhD or Master's Degree in Psychiatry or related field.

*[(108)]***(106)** Provider directory. A listing of network providers within a health plan.

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

*[(110)]***(108)** 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 *[an enrollee]* **member** if the plan normally provides coverage for dependent children.

*[(111)]***(109)** Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

*[(112)]***(110)** Refractions. A record of the patient's preference for the focusing of the eyes that *[can]* **may** then be used to purchase eyeglasses **or contact lenses**. It is the *[portion of the eye]* **part of the** exam that determines what prescription lens *[provides]* **gives** the patient *[with]* the best possible vision.

*[(113)]***(111)** Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

*[(114)]***(112)** Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020*[(5)(B)]***(7)(B)** and is currently receiving a monthly retirement benefit from *[one (1) of the]* **a** retirement system*[s]* listed in such rule.

[(115) Second opinion program. A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.]

*[(116)]***(113)** Skilled nursing care. *[Care which]* **Services that** must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

*[(117)]***(114)** Skilled nursing facility (SNF). *[An institution which meets fully each of the following requirements:*

(A) It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board, and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

(B) It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).] **A public or private facility licensed and operated according to the law that provides—**

(A) Permanent and full-time facilities for ten (10) or more resident patients;

(B) A registered nurse or physician on full-time duty in charge of patient care;

(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;

(D) A daily medical record for each patient;

(E) Transfer arrangements with a hospital; and

(F) A utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.

*[(118)]***(115)** 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.

*[(119)]***(116)** 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.

*[(120)]***(117)** Specialty medications. High cost drugs that are primarily self-injectible**;** *[but]* sometimes oral medications.

*[(121)]***(118)** State. Missouri.

*[(122)]***(119)** Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before *[stepping up to]* **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.

*[(123)]***(120)** 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 participant and recover the money directly from the other insurer.

*[(124)]***(121)** Subscriber. The employee or member who elects coverage under the plan.

[(125) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.]

*[(126)]***(122)** Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

*[(127)]***(123)** Surgery center (ambulatory). A hospital-based, **hospital-**sponsored, or independently-owned facility that performs surgery.

*[(128)]***(124)** Survivor. A member who meets the requirements of subsection 22 CSR 10-2.020*[(5)(A)]***(7)(A)**.

(125) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[(129) Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

(A) Stepchild(ren);

(B) Foster child(ren) for whom the employee is responsible for health care;

(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; and

(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

1. Except for a disabled child(ren) as described in section (87) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

(E) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan.]

*[(130)]***(126)** Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

*[(131)]***(127)** Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(132)]***(128)** Usual, Customary, and Reasonable charge.

(A) Usual. The fee a *[physician]* **provider** most frequently charges the majority of his/her patients for the same or similar services.

(B) Customary. The range of fees charged in a geographic area by *[physicians]* **providers** of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the *[doctors]* **providers** for ninety percent (90%) of the procedures reported.

*[(133)]***(129)** Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

(130) Vendor. The current applicable third-party administrator of MCHCP benefits.

*[(134)]***(131)** Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020*[(5)(B)]***(7)(B)**.

(132) Wellness participation year. Year in which members may participate in the wellness program per plan year: October 1–September 25.

(133) Wellness program. A voluntary program focusing on awareness, health education, and behavior change.

(134) Wellness premium. The monthly medical premium applied to members who successfully complete all requirements of the Lifestyle Ladder program.

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 Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. 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 *[Subscriber Agreement and]* **General Membership Provisions**. The Missouri Consolidated Health Care

Plan is amending the rule title and purpose; amending sections (1)–(3) and (5)–(10); adding new sections (5), (6), and (11)–(13); and renumbering as necessary.

PURPOSE: This amendment changes the policy of the board of trustees in regard to the General Membership Provisions of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the [Subscriber Agreement and] General Membership Provisions of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. 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 MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This 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. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) *[The participant's initial application, any subsequently accepted modifications to such application, the handbook, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any other written materials interpreting the subscriber agreement for the benefit of members and administrators are not a part of the subscriber agreement.]* **The member handbook and plan document provides the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). The member warrants that the information s/he provides in the enrollment process, whether by online enrollment in the Statewide Employee Benefit Enrollment System (SEBES), Open Enrollment, written form, or in other such organized methods, are true and accurate representation of fact.**

(A) By *[applying for]* **enrolling in** coverage under the MCHCP, a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks; **and**

[2. Individual and family deductibles, if appropriate, will be applied; and]

*[3.]***2.** Any individual eligible as an employee shall not be covered as a dependent unless the employee is **under the age of twenty-six (26) or is** on an approved leave of absence.

(B) A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov within thirty-one (31) days of his/her hire date. A new employee's coverage begins on the first day of the month after enrollment. A new employee will receive a SEBES enrollment password by email if the employee's human resource/payroll representative enters a valid email address in SEBES. Otherwise, the SEBES password will be mailed to the new employee's home address.

(C) An employee who does not enroll or waive medical coverage within the first thirty-one (31) days will be automatically enrolled in the PPO 600 Plan effective the first day of the month following the end of his/her thirty-one (31)-day eligibility period. The automatic enrollment will apply only to the employee and not to any of his/her dependents.

(D) A dependent may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(E) A member cannot be covered as a subscriber and a dependent.

(F) A dependent may have dual coverage if his/her parents are divorced or have never married and are both covered under an MCHCP medical plan.

1. MCHCP will only pay a service once regardless if the claim for the dependent's service is filed under multiple subscribers' coverage. MCHCP will process the claim and apply applicable cost-sharing using coverage through the subscriber who files the claim first. The second claim for the same services will not be covered.

2. If a provider files a claim simultaneously under both subscribers, the claim of the subscriber with the birthday first in the calendar year will be processed and applicable cost-sharing will be determined.

3. If a dependent has coverage under two (2) subscribers, the dependent will have a separate deductible and coinsurance under each subscriber.

(2) The effective date of participation shall be determined, subject to the effective date provision in subsection (2)(C), as follows:

(A) Employee Participation.

1. If *[application]* **enrollment** by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility*[;]***.**

2. If *[application]* **enrollment** by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date the *[application]* **enrollment** is received*[, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and]***.**

3. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or re-employment.

4. Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan, and their eligible dependents who were covered by the other medical care plan, are eligible for participation immediately.

5. Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.

6. Employees who terminate all employment with the state (not simply move from one (1) agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation or, at the employee's choice, on the first day of the month following the employee's date of rehire. If the employee

chooses the first day of the month following his/her date of rehire, he/she will be considered a new hire and can add dependents or change plans.

*[3.]***7.** Not limiting or excluding any of the other provisions, if *[application]* **enrollment** is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if one (1) of the following occurs:

A. Occurrence of a life event which includes marriage, birth, adoption, and placement of **adopted** children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. *[Application]* **Enrollment** must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case *[application]* **enrollment** for coverage through the plan must be made within sixty (60) days of loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a *[child]* **newborn** is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the *[application]* **enrollment**. *[Application]* **Enrollment** for participants must be made in accordance with the following provisions. Effective dates for all dependent coverage is wholly dependent upon—

1. Proof of eligibility documentation is required for all dependents. The plan reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by the plan administrator, coverage for the applicable dependent will either be terminated or will never take effect.

A. For the addition of dependents: Required documentation should accompany the *[application]* **enrollment** for coverage, except when adding a newborn. Failure to provide acceptable documentation with the *[application]* **enrollment** will result in the dependent not having coverage until such proof is received, subject to the following:

(I) If proof of eligibility is not received with the *[application]* **enrollment**, such proof will be requested by letter sent to the subscriber. Documentation shall be received no later than thirty (30) days from the date of the letter requesting such proof. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period unless a life event occurs; and

(II) Coverage is provided for a newborn of a member from the moment of birth. **A change form, available by accessing state member information at www.mchcp.org, and proof of eligibility must be submitted prior to the birth or within the applicable time frame required by law.** *[However, c]***C**overage will not continue past the first thirty-one (31) days unless required documentation is received;

2. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death;

3. Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	• **Government-issued** */B/***b**irth certificate*[;]* or **other government-issued or legally-certified proof of eligibility** *[• Hospital certificate]*
Addition of step-child(ren)	• Marriage license to biological parent of child(ren); and • Birth *[or Hospital]* certificate for child(ren) that names the subscriber's spouse as a parent
Addition of foster child(ren)	• Placement papers in subscriber's care
Adoption of dependent(s)	• Adoption papers*; [or]* • Placement papers**; or** • **Filed petition for adoption**
Legal guardianship of dependent(s)	• Court-documented guardianship papers (Power of Attorney is not acceptable)
Newborn of covered dependent	• **Government-issued** */B/***b**irth certificate for newborn listing covered dependent as parent with baby's name and birth date
Marriage	• Marriage license; • Marriage certificate; or • Newspaper notice of the wedding
Divorce	• Final divorce decree; or • Notarized letter from spouse stating he/she is agreeable to termination of coverage pending divorce
Death	• Death certificate

4. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number*[, if available]*. **Members who are eligible for Medicare benefits under Part A, B, or D must notify the plan administrator of their eligibility and provide a copy of the member's Social Security and Medicare cards within thirty-one (31) days of eligibility of Medicare.** Claims will not be processed until the required information is provided;

5. If an employee makes concurrent *[application]* **enrollment** for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

6. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if *[application]* **enrollment** is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; and

7. Survivors, retirees, vested subscribers, and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage, *[except]* **add dependents under the age of twenty-six (26) at open enrollment for the**

2011 plan year only, add a newborn of a covered dependent, or when a dependent's employer-sponsored coverage ends due to one (1) of the following:

A. Termination of employment;

B. Retirement; *[and]* **or**

C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) Effective Date Provision. The effective date of coverage is the first of the month coinciding with or following the eligibility date and the date the form is received by the plan. The effective date of coverage cannot be prior to the date of receipt of the enrollment form by the plan. **The effective date is determined by the date the enrollment is received by the plan administrator.** The effective date for dependent coverage is wholly dependent upon the appropriate proof of eligibility documentation being timely received by the plan (see **paragraph** (2)(B)1.);

(D) *[Application]* **Enrollment** for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's—

1. Employer-sponsored medical, dental, or vision plan terminates or coverage by the employer is no longer offered;

2. The employer contributions toward the premiums cease;

3. COBRA coverage ceases; or

4. A dependent no longer qualifies due to age;

(E) *[Application]* **Enrollment** may be made for dependent coverage within sixty (60) days *[of the event—]* **for a dependent who no longer qualifies for Medicaid;**

[1. A Qualified Medical Child Support Order is received; or

2. A dependent no longer qualifies for Medicaid; or]

(F) *[Application may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.]* **A Qualified Medical Child Support Order is effective the first of the month coinciding with or the month following the date the form is received by the plan.**

(3) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written or phone request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; *[or]*

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as **expressly** specified *[in sections (4) and (5)]* **otherwise in this rule**.

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this *[rule]* **chapter** or upon failure to provide the plan with acceptable proof of eligibility with the following exception: *[unemancipated]* mentally and/or physically handicapped children will continue to be eligible beyond age *[twenty-five (25)]* **twenty-six (26)** during the continuance of a permanent disability provided **the following** documentation *[satisfactory to the plan administrator]* is *[furnished by a physician]* **submitted to the plan** prior to the dependent's twenty-*[fifth]***sixth** birthday*[, and as requested at the discretion of the plan administrator]***:**

A. The SSI Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

B. A letter from the dependent's physician describing the disability and verifying that the disability predates the SSA determination; and

C. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section *[(5)]***(7)**.

4. Subscriber shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter;

(E) Termination due to fraud or intentional misrepresentation; or

(F) A retroactive rescission will apply only to non-payment of a premium, fraud, or intentional misrepresentation.

(5) Terminating medical coverage is not an allowable reason to cancel dental and/or vision coverage during the year. A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents for one (1) of the following reasons:

(A) Termination of employment;

(B) Termination of COBRA coverage;

(C) Retirement;

(D) Death;

(E) Leave of absence; or

(F) Dependent age of twenty-six (26).

(6) Voluntary Cancellation of Coverage. A subscriber may retroactively cancel coverage for one (1) of the following reasons:

(A) Cancellation of coverage on his/her spouse on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request; or

(B) Cancellation of coverage effective the last day of the prior month if the subscriber notifies MCHCP on the first calendar day of the current month.

*[(5)]***(7)** Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if the active employee was vested and eligible for a future retirement benefit and eligible dependents meet one (1) of the following conditions:

1. They have had coverage through MCHCP since the effective date of the last open enrollment period;

2. They have had other health insurance for the six (6) months immediately prior to the employee's death—proof of insurance is required; or

3. They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers**,** and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in *[(5)(B)4.]* **paragraph (7)(B)4.**; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity, or the Missouri Department of Transportation and Highway Patrol Employees' Retirement System when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of *[the Missouri Consolidated Health Care Plan]* **MCHCP** when the approved leave began, but who subsequently terminated participation in *[the Missouri Consolidated Health Care Plan]* **MCHCP** while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (3)(C). Coverage may be reinstated upon return from military leave. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(E) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation terminates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (subscriber only or subscriber and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (subscriber only or subscriber and dependents) upon returning to employment.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. **If the employee does not continue coverage, s/he will be considered a new hire and may enroll in the plan of his/her choice.**

*[(6)]***(8)** Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with *[the]* COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A spouse and dependents may continue coverage for up to thirty-six (36) months at their expense if the covered employee enrolls in Medicare and notifies the plan administrator within sixty (60) days of his/her Medicare entitlement.

*[2.]***3.** A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

*[3.]***4.** A divorced spouse **and dependents** may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

[4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.]

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or

return to their position of employment following leave.

*[7.]***8.** Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

*[8.]***9.** All operations under the COBRA provision will be applied in accordance with federal regulations.

*[(7)]***(9)** Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) if: a) The member continues and maintains coverage under the thirty-six (36)-month provision of COBRA; and b) The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the *[application]* premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

*[(8)]***(10)** If any retired participants or long-term disability recipients, **or** their *[eligible]* dependents, *[or surviving dependents]* eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage. **If surviving dependents do not elect to continue their coverage within thirty-one (31) days of the first day of the month following the date of death, they may not later elect to be covered.**

(11) Retirees and/or dependents may continue dental and/or vision coverage into retirement without medical coverage. At retirement, employees may add themselves and/or their dependents with proof of six (6) months of dental and/or vision coverage immediately prior to their employment termination date.

(12) Medicare.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, 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 was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims.

(B) If a participant eligible for Medicare Part D enrolls in a Medicare Part D plan in addition to coverage under this plan, such participant's benefit may be adjusted in order for the plan to avoid liability for filing a false claim under the subsidy reimbursement portion of Medicare Part D.

(13) Communications to Members.

(A) It is the member's responsibility to ensure that the plan administrator has current contact information for the member and any dependent(s).

(B) A member must notify the plan administrator of a change in his/her mailing or email address as soon as possible, but no later than thirty (30) days of the change.

(C) It is the responsibility of all active employees and any members who elect to receive plan communication through email to ensure plan emails are not blocked as spam or junk mail by the member or by the member's service provider.

(D) Failure to update a mailing or email address may result in undeliverable mail/email of important informational material. All members will be held responsible for the content of communications mailed/emailed from the plan to members provided such communication is sent by the plan to the most recent contact information on file with the plan at the time of the mailing, and members who fail to receive a communication as a result of failing to update his/her mailing/email address may incur additional liability or miss member opportunities relating to their covered benefits.

*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 Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. 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 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan medical plans.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. 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 MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This 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. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program *[consists of four (4) parts, as described in the following]* **has the following components**:

(A) *[Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate claims administrator. For emergency hospital admissions, the claims administrator must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;]* **Prior authorization of services—The claims administrator must authorize some**

services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Participants who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergency use whether air or ground;

B. Applied behavioral analysis for autism;

C. Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;

D. Chiropractic services after twenty-six (26) visits annually;

E. Cochlear implant device;

F. Dental care to reduce trauma and restorative services when the result of accidental injury;

G. Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

H. Genetic testing or counseling;

I. Home health care and palliative services;

J. Hospice care;

K. Hospital inpatient services except for observation stays;

L. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

M. Nutritional counseling after three (3) sessions annually;

N. Orthotics over one thousand dollars ($1,000);

O. Oxygen provided on an outpatient basis;

P. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

Q. Prostheses over one thousand dollars ($1,000);

R. Skilled nursing facility;

S. Surgery (outpatient)—The following outpatient surgical procedures: potential cosmetic surgery, sleep apnea surgery, implantable stimulators, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams; surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitus; incision of accessory sinuses, salivary glands, or ducts; or frenectomy); and

T. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications. Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider;

C. Medications that may be prescribed for several conditions including some where treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will *[continue to]* monitor the medical necessity of the **inpatient** admission *[and approve]* **to certify the necessity of** the continued stay in the hospital. *[Retirees and other participants for whom Medicare is the primary payor]* **Participants who have another primary carrier, including Medicare,** are not subject to this provision; **and**

[(C) Large Case Management—Members who require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases, this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits.]

(C) Retrospective Review—Reviews conducted after services have been provided to a patient. The retrospective review includes an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment.

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 Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. 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 10-2.050 Copay Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees to the Copay Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because it is no longer needed.

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. 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 MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This 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. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed December 20, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

*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 rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expires June 29, 2011. 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 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 sections (1)–(3).

PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. 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 MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This 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. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars ($300); family limit each calendar year, six hundred dollars ($600). Non-network: per individual each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

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

(C) Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to 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 report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.

(D) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once **the** out-of-pocket maximum is reached.

(D) Claims *[may also]* **shall** be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within *[fifty (50)]* **one hundred (100)** miles of his/her home. The participant must contact the claims administrator **before the date of service** in order to have a local provider approved. Such approval is *[not permanent]* **for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability**.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; *[percentage amount coinsurance is reduced as a result of noncompliance with prior authorization; coinsurance amounts related to infertility benefits;]* **the amount the member pays due to noncompliance;** and charges above the maximum allowable amount for transplants performed by a non-network provider.

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. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. 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 RULE

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. 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 MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200). Non-network: per individual each calendar year, one thousand two hundred dollars ($1,200); family limit each calendar year, two thousand four hundred dollars ($2,400).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

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

(C) Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to 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 report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.

(D) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The participant must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—one thousand five hundred dollars ($1,500).

(B) Network out-of-pocket maximum for family—three thousand dollars ($3,000).

(C) Non-network out-of-pocket maximum for individual—three thousand dollars ($3,000).

(D) Non-network out-of-pocket maximum for family—six thousand dollars ($6,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. A proposed rule 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 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5) and adding new sections (6) and (7).

PURPOSE: This amendment changes the policy of the board of trustees in regard to the High Deductible Health Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. 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 MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This 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. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars ($1,200); family limit each calendar year, two thousand four hundred dollars ($2,400). Non-network: per individual each calendar year, two thousand four hundred dollars ($2,400); family limit each calendar year, four thousand eight hundred dollars ($4,800).

(A) The family deductible must be met before claim payments begin, applicable when two (2) or more family members are covered.

(B) If both a husband and wife are state employees covered by Missouri Consolidated Health Care Plan (MCHCP) and they both enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), they must each have a separate HSA. The maximum contribution MCHCP will make for the family is one thousand four hundred dollars ($1,400) regardless of the number of HSAs or the number of children covered under the HDHP 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 seven-hundred-dollar ($700) contribution to each spouse, to total one thousand four hundred dollars ($1,400).

(C) Married, active employees who are MCHCP subscribers need to 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 report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.

(D) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once **the** out-of-pocket maximum is reached.

(D) Claims *[may also]* **shall** be paid at eighty percent (80%) if the subscriber requires covered services that are not available through network provider within *[fifty (50)]* **one hundred (100)** miles of his/her home. The participant must contact the claims administrator **before the date of service** in order to have a local provider approved. Such approval is *[not permanent.]* **for three (3) months. After three (3) months, the participant must contact the claims administrator to reassess network availability.**

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; *[percentage amount coinsurance is reduced as a result of non-compliance with prior authorization]* **the amount the member pays due to noncompliance**; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Pharmacy benefits are subject to the *[applicable medical plan]* **HDHP** deductible and coinsurance.

(6) A member does not qualify for the HDHP if they are covered under or enrolled in any of the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

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

(D) Health reimbursement account (HRA); or

(E) The participant has veteran's benefits that have been used within the past three (3) months.

(7) A member 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.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009.

*Original rule filed Dec. 22, 2008, effective June 30, 2009. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. 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 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

PURPOSE: This amendment changes the policy of the board of trustees in regard to the Medicare Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. 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 MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This 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. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Eligibility—Subscribers and dependents covered in this plan must be enrolled in Medicare, and the subscribers must **be eligible to** receive a monthly retirement benefit from either the Missouri State Employees' Retirement System (MOSERS) or from the Public School Retirement System (PSRS), based on years of service. A subscriber may enroll in this plan when first eligible for Medicare **or during open enrollment**.

(2) Available services—The Medicare Supplement Plan *[covers coinsurance amounts on]* **includes the following benefits relating to** Medicare Parts A and B eligible benefits after the **applicable** Medicare deductibles are met*[.]***:**

(A) Inpatient hospitalization—coverage for coinsurance for day sixty-one (61) through day ninety (90);

(B) Inpatient hospitalization—coverage for coinsurance for lifetime reserve days ninety-one (91) through one hundred fifty (150);

*[(A)]***(C)** Inpatient *[hospital care]* **hospitalization**—covers Medicare Part A coinsurance plus coverage for three hundred sixty-five (365) additional days after Medicare coverage ends;

*[(B)]***(D)** Medical costs—covers Medicare Part B coinsurance;

*[(C)]***(E)** Blood—covers the first three (3) pints of blood each year; and

[(D) Prescription drug coverage.]

(F) Hospice—coverage for the five percent (5%) coinsurance for Medicare-approved charges for inpatient respite care and five percent (5%) coinsurance up to a five-dollar ($5) coinsurance maximum for prescription pain medications.

*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. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expires June 29, 2011. 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 sections (1) and (2).

PURPOSE: This amendment changes the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. 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 MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2011, in order that an immediate danger is not imposed on the public welfare. This 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. MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed December 22, 2010, becomes effective January 1, 2011, and expires on June 29, 2011.*

(1) Benefit Provisions Applicable to the *[HMO, Copay,]* PPO 300,

PPO 600, and **High Deductible Health Plan (**HDHP**)** Plans.

[(A)] Subject to the plan provisions**,** *[and]* limitations**,** and *[the written application]* **enrollment** of the employee, the benefits are payable for covered charges incurred by a participant while covered under the plans, provided the deductible requirement, if any, is met.

[(B) Any deductible requirement applies each calendar year to covered charges. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount.

(C) Any family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement.

(D) The total amount of benefits payable for all covered charges incurred non-network during an individual's lifetime shall not exceed the lifetime maximum.]

(2) Covered Charges Applicable to the *[HMO, Copay,]* PPO 300, **PPO 600,** and HDHP Plans.

(A) Only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a noncovered service, and which are*[:]***—**

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;

2. To the extent they do not exceed any limitation;

3. Not excluded by the limitations; and

4. For not more than the usual, reasonable, and customary charge**,** as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and

2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

(C) A physician visit to seek a second opinion is a covered service.

(D) Plan benefits for the PPO 300, PPO 600, and HDHP plans are as follows:

STATE BENEFITS
Allergy Serum **Multi-dose vial** **No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers or air ventilation system cleaning.**
Ambulance Service **Non-emergency air or ground excluded unless prior authorization received from medical plan.** **Use of air ambulance or medical helicopter service from any continent returning to the U.S. is excluded.**
Applied Behavioral Analysis for Autism **For children younger than age 19** **The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement and functional analysis of the relationship between environment and behavior.** **$40,000 annual limit. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary.** **Prior authorization by medical plan required.**
Birth Control Prescriptions
Birth Control Devices and Injections **Administered in the physician's office.**
Cardiac and Pulmonary Rehabilitation **Up to 36 visits within a 12-week period per incident** **Prior authorization by medical plan required after 36 visits within a 12-week period.**
Chelation Therapy **Limited to treatment of lead poisoning in children as recommended by Missouri Department of Health and Senior Services.**
Chiropractic Services **Up to 26 visits annually** **Prior authorization by medical plan required after 26 visits annually.**
Cochlear Implant Device **Prior authorization by medical plan required.**
Colonoscopy
Convenient Care Clinic (CCC)

Dental Care/Accidental Injury **Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors or cysts. Treatment must be initiated within 60 days of accident.** **No coverage for dental care, including oral surgery, as a result of poor dental hygiene.** **Prior authorization by medical plan required.**
Durable Medical Equipment (DME)/Medically Necessary Disposable Supplies **Basic equipment that meets medical needs. DME includes, but is not limited to, augmentative communication devices and manual and powered mobility devices. Includes repair and replacement due to normal wear and tear, if there is a change in medical condition or if growth-related. Disposable supplies that do not withstand prolonged use and are periodically replaced include, but are not limited to, colostomy and ureterostomy bags and prescription compression stockings.** **No coverage for non-reusable disposable supplies including but not limited to bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies including oral appliances.** **Prior authorization by medical plan required for durable medical equipment over $1,500 and/or rentals over $500/month.** **Prescription compression stockings are limited to two pairs or four individual stockings per plan year.**
Emergency Room Services **If admitted to hospital, may be required to transfer to network facility for maximum benefit. Paid as network benefit.**
Enteral Feedings (Tube Feeding) **Nutritional supplements that are prescribed by a physician and administered through enteral feedings, provided they are the sole source of nutrition and the member has a permanent condition, or partial nutrition during transition. This includes nutritional and electrolyte supplements and supplies related to enteral feedings (for example, feeding tubes, pumps and other materials used to administer enteral feedings).**
Flu Shot/Nasal Spray (FluMist®) **Covered at 100% when administered in a network physician's office. When shot is obtained elsewhere, the member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive reimbursement up to $25. Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.**
Genetic Testing or Counseling **Genetic testing or counseling as part of treatment for a medical condition** **No coverage for testing based on family history.** **Prior authorization by medical plan required.**

Hair Analysis and Prostheses **Limited to prostheses and expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or alopecia totalis for children 18 years of age or younger. Annual maximum $200. Lifetime maximum $3,200.** **No coverage for services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.**
Hearing Aids (Per Ear) **Covered once every two years. Member pays coinsurance amount per hearing aid. If hearing aid cost exceeds the amount listed below, member is also responsible for charges over that amount.** **Conventional: $1,000** **Programmable: $2,000** **Digital: $2,500** **BAHA: $3,500**
Hearing Testing **One hearing test per year. Additional hearing tests are covered if recommended by physician.**
Home Health Care/Palliative Services **Prior authorization by medical plan required.**
Hospice Care **Inpatient or Outpatient** **Includes bereavement and respite care.** **Prior authorization by medical plan required.**
Hospital Benefits - Inpatient Room and Board **Based on semi-private room** • **Medical (including outpatient services)** • **Mental Health (including outpatient services)** • **Chemical Dependency (including outpatient services)** • **Observation for Medical, Mental Health or Chemical Dependency** **Except for observation, prior authorization by medical plan required.**
Immunizations (Age-appropriate Adult and Pediatric) **Specified schedule of immunizations including, but not limited to, polio, rubella, measles, mumps, tetanus, whooping cough, diphtheria, hepatitis A and B, haemophilus influenzae type B (Hib), human papillomavirus, shingles, chicken pox, meningitis and pneumonia.** **Not covered when requested by third party or for travel.** **Immunizations required by the Missouri Department of Health and Senior Services or recommended by the Centers for Disease Control and Prevention.**
Injections and Infusions **Administered in the physician's office.**
Lab and X-ray
Mammograms **One mammogram per year. Additional mammograms are covered if recommended by physician.**
Mastectomies **No time frame on receiving reconstructive surgery or prostheses after mastectomies necessary to restore symmetry, as recommended by physician.**

Maternity Coverage **Newborns and their mothers are allowed hospital stays of at least 48 hours after normal birth and 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-visit minimum, at least one in the home.** **Prior authorization by medical plan required for maternity stays longer than 48 hours (normal delivery) or 96 hours (C-section).**
Mental Health/Chemical Dependency (Office Visit)
Nutrient Supplements **Formula and low-protein modified food products recommended by physician and limited only to treatment of Phenylketonuria (PKU) or any inherited disease of amino and organic acids**
Nutritional Counseling **Up to three sessions annually with registered dietitian, not limited by diagnosis. Up to three additional sessions considered with referral and medical diagnosis.** **Prior authorization by medical plan required after three sessions annually.**
Office Visit **Primary Care Physicians** **Specialists**

Orthotics

Therapeutic Shoes for Diabetics

Therapeutic shoes, inserts, and/or modifications to therapeutic shoes are covered if the following criteria are met:

- **The patient has diabetes mellitus; and**
- **The patient has one or more of the following conditions:**
  - **Previous amputation of the other foot, or part of either foot, or**
  - **History of previous foot ulceration of either foot, or**
  - **History of pre-ulcerative calluses of either foot, or**
  - **Peripheral neuropathy with evidence of callus formation of either foot, or**
  - **Foot deformity of either foot, or**
  - **Poor circulation in either foot; and**
- **The certifying physician who is managing the patient's systemic diabetes condition has certified that indications noted in this *Therapeutic Shoes for Diabetics* section are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.**

For adult patients meeting these criteria, coverage is limited to one of the following within one year:

- **One pair of custom molded shoes (which includes inserts provided with these shoes) and 2 additional pairs of inserts; or**
- **One pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes).**

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom molded shoes. See Orthopedic Footwear benefit.

There is no separate payment for the fitting of the shoes, inserts, or modifications or for the certification of need or prescription of the footwear.

Spinal Orthoses

A thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis is covered when it is ordered for one of the following indications:

- **To reduce pain by restricting mobility of the trunk; or**
- **To facilitate healing following an injury to the spine or related soft tissues; or**
- **To facilitate healing following a surgical procedure on the spine or related soft tissue; or**
- **To otherwise support weak spinal muscles and/or a deformed spine.**

Helmets

Helmets are provided when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living. These devices are not provided for use during sports-related activities.

Cranial Orthosis for Plagiocephaly

Plagiocephaly describes an asymmetrically shaped head. Synostotic plagiocephaly (craniosynostosis) is due to the premature closure of the cranial sutures. In non-synostotic plagiocephaly, also referred to as positional or deformational, the cranial sutures remain open. 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.

Dynamic orthotic cranioplasty, which may also be referred to as cranial molding, molding helmet, cranial banding, or cranial orthosis, is considered medically necessary only as an adjunct to operative therapy following surgery for craniosynostosis. Molding helmet therapy, including dynamic orthotic cranioplasty, is not a covered benefit for the non-operative management of positional or non-synotic plagiocephaly.

Initial reimbursement shall cover any subsequent revisions.

Cervical Orthoses

A cervical orthosis is covered when it is ordered for one of the following indications:

- **To reduce pain by restricting mobility of the neck; or**
- **To facilitate healing following an injury to the cervical spine or related soft tissues; or**
- **To facilitate healing following a surgical procedure on the cervical spine or related soft tissue; or**
- **To otherwise support weak cervical muscles and/or a deformed cervical spine.**

Hip Orthoses

A hip orthosis is covered when it is ordered for one of the following indications:

- **To reduce pain by restricting mobility of the hip; or**
- **To facilitate healing following an injury to the hip or related soft tissues; or**
- **To facilitate healing following a surgical procedure on the hip or related soft tissue; or**
- **To otherwise support weak hip muscles and/or a hip deformity.**

Knee Orthoses

A knee orthosis is covered when it is ordered for one of the following indications:

- **To reduce pain by restricting mobility of the knee; or**
- **To facilitate healing following an injury to the knee or related soft tissues; or**
- **To facilitate healing following a surgical procedure on the knee or related soft tissue; or**
- **To otherwise support weak knee muscles and/or a knee deformity.**

These devices are not provided solely for use during sports-related activities.

Ankle–Foot/Knee–Ankle–Foot (AFO) Orthoses

AFOs Not Used During Ambulation

A static AFO is covered if the following criteria are met:

- **Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); and,**
- **Reasonable expectation of the ability to correct the contracture; and,**
- **Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and,**
- **Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; OR**
- **The patient has plantar fasciitis.**

If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff or caregiver. A static AFO and replacement interface will be denied as not medically necessary if the contracture is fixed. A static AFO and replacement interface will be denied as not medically necessary for a patient with a foot drop but without an ankle flexion contracture. A component of a static AFO that is used to address positioning of the knee or hip will be denied as not medically necessary because the effectiveness of this type of component is not established.

If a static AFO is covered, a replacement interface is covered as long as the patient continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not medically necessary.

A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities.

AFOs and KAFOs Used During Ambulation

AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

Knee–ankle–foot orthoses (KAFO) are covered for ambulatory patients for whom an ankle–foot orthosis is covered and for whom additional knee stability is required.

If the basic coverage criteria for an AFO or KAFO are not met, the orthosis will be denied as not medically necessary. AFOs and KAFOs that are molded-to-patient-model, or custom-fabricated, are