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Part I

SALUS POPULI SUPREMA LEX ESTO

*“The welfare of the people shall be the supreme law.”*



JOHN R. ASHCROFT  
SECRETARY OF STATE

MISSOURI  
REGISTER

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Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
August 1, 2018	<b>September 4, 2018</b>	September 30, 2018	October 30, 2018
August 15, 2018	<b>September 17, 2018</b>	September 30, 2018	October 30, 2018
September 4, 2018	<b>October 1, 2018</b>	October 31, 2018	November 30, 2018
September 17, 2018	<b>October 15, 2018</b>	October 31, 2018	November 30, 2018
October 1, 2018	<b>November 1, 2018</b>	November 30, 2018	December 30, 2018
October 15, 2018	<b>November 15, 2018</b>	November 30, 2018	December 30, 2018
November 1, 2018	<b>December 3, 2018</b>	December 31, 2018	January 30, 2019
November 15, 2018	<b>December 17, 2018</b>	December 31, 2018	January 30, 2019
December 3, 2018	<b>January 2, 2019</b>	January 29, 2019	February 28, 2019
December 17, 2018	<b>January 15, 2019</b>	January 29, 2019	February 28, 2019

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

## HOW TO CITE RULES AND RSMO

### RULES

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

<b>Title</b>		<b>Division</b>	<b>Chapter</b>	<b>Rule</b>
3	CSR	10-	4	.115
Department	<i>Code of State Regulations</i>	Agency Division	General area regulated	Specific area regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation, for example, 3 CSR 10-4.115 NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

### ***Code and Register on the Internet***

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The *Code* address is [www.sos.mo.gov/adrules/csr/csr](http://www.sos.mo.gov/adrules/csr/csr)

The *Register* address is [www.sos.mo.gov/adrules/moreg/moreg](http://www.sos.mo.gov/adrules/moreg/moreg)

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

**R**ules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2016. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

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

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

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

**EMERGENCY AMENDMENT**

**12 CSR 10-41.010 Annual Adjusted Rate of Interest.** The Director of Revenue proposes to amend section (1) to reflect the interest to be charged on unpaid, delinquent taxes.

*PURPOSE:* This emergency amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2019.

*EMERGENCY STATEMENT:* The Director of Revenue is mandated to establish not later than October 22 annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percent. This emergency amendment is necessary to ensure public awareness and to preserve a compelling governmental interest requiring an early effective date in that the amendment informs the public of the established rate of interest to be paid on unpaid amounts of taxes for the 2019 calendar year. A proposed amendment, that covers the same material, is published in this issue of the *Missouri Register*. The director has limited the scope of the emergency amendment to the circumstances creating the emergency. The director has followed procedures calculated to assure fairness to all interested persons and parties and has complied

with protections extended by the *Missouri* and *United States Constitutions*. This emergency amendment was filed October 22, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

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

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%
2017	4%
2018	4%
<b>2019</b>	<b>5%</b>

*AUTHORITY:* section 32.065, RSMo 2016. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Oct. 22, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 30—Division of Regulation and Licensure  
Chapter 1—Controlled Substances**

**EMERGENCY AMENDMENT**

**19 CSR 30-1.002 Schedules of Controlled Substances.** The department is amending section (1) Schedules of Controlled Substances.

*PURPOSE:* This emergency amendment updates the list of all drugs falling within the purview of controlled substances to match the corresponding list promulgated by the Drug Enforcement Administration (DEA).

**EMERGENCY STATEMENT:** Since this rule was last amended, the DEA has issued several scheduling actions, all but two (2) of which have included adding drugs to the Schedule One list – the list of unlawful controlled substances used illicitly as street drugs. Adding these drugs to Schedule One allows municipal, county, and state law enforcement and prosecutors to enforce crimes related to these drugs; if the drugs are not scheduled, there are no criminal consequences for their unlawful use, possession, sale, or manufacture. The majority of drugs being added to Schedule One are synthetic drugs created when illicit organizations have slightly altered the molecular and chemical compound structure so the new drug does not fall under previous restrictions. This constant restructuring forces the DEA and states to continuously update their schedule lists with the new compounds in order to protect the public's health and safety. Drugs like synthetic fentanyl can now be included in Schedule One and combatted to avoid their further contributions to the state's opioid crisis related deaths and overdoses. A generic version of an isomer THC, the primary psychoactive substance in marijuana, is being added to Schedule Two for the treatment of anorexia associated with weight loss in patients with AIDS and for the treatment of nausea and vomiting resulting from cancer chemotherapy in patients who failed to respond to conventional anti-emetic therapies. Finally, approved cannabidiol drugs have been added to Schedule Five. Missouri enacted previous legislation to allow two (2) companies in Missouri to manufacture and dispense cannabidiol (CBD oil) drugs for patients with intractable seizures. However, because the drug was not approved by the FDA and the DEA, it was not covered by insurance and patients were forced to pay cash and could only receive the medication from select distributors. Since 2014, 367 Hemp Extract Registration Cards have been issued in Missouri, with 184 cards still being active, including 124 cards issued to minors. Recently, a new cannabidiol drug has been approved by the FDA and the DEA. The emergency scheduling of this drug in Schedule Five will allow Missouri physicians to prescribe these drugs to Missouri patients for seizures, wasting syndrome, nausea, and for the more effective pain management through the reduction of opiate use. These drugs will be available in pharmacies by prescription and covered by insurance, greatly increasing their accessibility to patients in need. This emergency amendment is necessary for the immediate protection of the public health, safety, and welfare due to the risk created by unregulated illicit drugs and also by the increased treatment potential of making approved Schedule Two and Five drugs available for use. The department finds a compelling governmental interest in protecting the public health, safety, and welfare, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the *Missouri and United States Constitutions*. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2018, becomes effective November 4, 2018, and expires May 2, 2019.

(1) Schedules of Controlled Substances.

(A) Schedule I shall consist of the drugs and other substances[,] by whatever official name, common or usual name, chemical name, or brand name designated[,] listed in this section. Each drug or substance has been assigned the Drug Enforcement Administration (DEA) Controlled Substances Code Number set forth opposite it.

1. Opiates. Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

- A. Acetyl-alpha-methylfentanyl (*[N/N*-(1-(1-methyl-2-phenethyl)-4-piperidinyl)-*[N/N*-phenylacetamide) 9815
- B. Acetylmethadol 9601
- C. Acetyl fentanyl (*N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide) 9821

<i>[C.]D.</i> AH-7921(3,4-dichloro- <i>[N/N</i> -(1-dimethylamino)cyclohexylmethyl] benzamide)	9551
<i>[D.]E.</i> Allylprodine	9602
<i>[E.]F.</i> Alphacetylmethadol (except levoalphacetylmethadol also known as levo-alpha-acetylmethadol levothadyl acetate or LAAM)	9603
<i>[F.]G.</i> Alphameprodine	9604
<i>[G.]H.</i> Alphamethadol	9605
<i>[H.]I.</i> Alpha-methylfentanyl ( <i>[N/N</i> -1-(alphamethyl-beta-phenyl) ethyl-4-piperidyl) propionanilide; 1-(1-methyl-2-phenylethyl)-4 ( <i>[N/N</i> -propanilido) piperidine)	9814
<i>[I.]J.</i> Alpha-methylthiofentanyl ( <i>[N/N</i> -(1-methyl-2-(2-thienyl) ethyl-4-piperidinyl)- <i>[N/N</i> -phenylpropanamide)	9832
<i>[J.]K.</i> Benzethidine	9606
<i>[K.]L.</i> Betacetylmethadol	9607
<i>[L.]M.</i> Beta-hydroxyfentanyl ( <i>[N/N</i> -(1-(2-hydroxy-2-phenethyl)-4-piperidinyl)- <i>[N/N</i> -phenylpropanamide)	9830
<i>[M.]N.</i> Beta-hydroxy-3-methylfentanyl ( <i>[o]</i> Other name: <i>[N/N</i> -(1-(2-hydroxy-2-phenethyl)-3-methyl-4-piperidinyl)- <i>[N/N</i> -phenylpropanamide <i>]/</i> )	9831
<i>[N.]O.</i> Betameprodine	9608
<i>[O.]P.</i> Betamethadol	9609
<i>[P.]Q.</i> Betaprodine	9611
<i>[Q.]R.</i> Clonitazene	9612
<i>[R.]S.</i> Dextromoramide	9613
<i>[S.]T.</i> Diampromide	9615
<i>[T.]U.</i> Diethylthiambutene	9616
<i>[U.]V.</i> Difenoxin	9168
<i>[V.]W.</i> Dimenoxadol	9617
<i>[W.]X.</i> Dimepheptanol	9618
<i>[X.]Y.</i> Dimethylthiambutene	9619
<i>[Y.]Z.</i> Dioxaphetyl butyrate	9621
<i>[Z.]AA.</i> Dipipanone	9622
<i>[AA.]BB.</i> Ethylmethylthiambutene	9623
<i>[BB.]CC.</i> Etonitazene	9624
<i>[CC.]DD.</i> Etoxadine	9625
<i>[DD.]EE.</i> Furethidine	9626
<i>[EE.]FF.</i> Hydroxypethidine	9627
<i>[FF.]GG.</i> Ketobemidone	9628
<i>[GG.]HH.</i> Levomoramide	9629
<i>[HH.]II.</i> Levophenacymorphan	9631
<i>[II.]JJ.</i> 3-Methylfentanyl ( <i>[N/N</i> - <i>[/]/</i> (3-methyl-1-(2-phenylethyl)-4-piperidyl)- <i>[N/N</i> -phenylpropanamide), its optical and geometric isomers, salts, and salts of isomers	9813
<i>[JJ.]KK.</i> 3-Methylthiofentanyl ( <i>[N/N</i> - <i>[/]/</i> (3-methyl-1-(2-thienyl)ethyl-4-piperidinyl <i>]/</i> )- <i>[N/N</i> -phenylpropanamide)	9833
<i>[KK.]LL.</i> Morpheridine	9632
<i>[LL.]MM.</i> MPPP (1-methyl-4-phenyl-4-propionoxypiperidine)	9661
<b>NN. MT-45 (1-cyclohexyl-4-(1,2-diphenylethyl) piperazine)</b>	<b>(9560)</b>
<i>[MM.]OO.</i> Noracymethadol	9633
<i>[NN.]PP.</i> Norlevorphanol	9634
<i>[OO.]QQ.</i> Normethadone	9635
<i>[PP.]RR.</i> Norpipanone	9636
<i>[QQ.]SS.</i> Para-fluorofentanyl( <i>[N/N</i> - <i>[/]</i> (4-fluorophenyl)- <i>[N/N</i> - <i>[/]</i> (1-(2-phenethyl)-4-piperidinyl <i>]/</i> ) propanamide	9812
<i>[RR.]TT.</i> PEPAP (1-(2-phenethyl)-4-phenyl-4-acetoxypiperidine)	9663
<i>[SS.]UU.</i> Phenadoxone	9637
<i>[TT.]VV.</i> Phenampromide	9638
<i>[UU.]WW.</i> Phenomorphan	9647

<i>/VV/XX</i> . Phenoperidine	9641
<i>/WW/YY</i> . Piritramide	9642
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<i>/YY/AAA</i> . Properidine	9644
<i>/ZZ/BBB</i> . Propiram	9649
<i>/AAA/CCC</i> . Racemoramide	9645
<i>/BBB/DDD</i> . Thiofentany <i>/N/N</i> -phenyl- <i>/N/N</i> -(1-(2-thienyl)ethyl-4-piperidinyl)-propanamide	9835
<i>/CCC/EEE</i> . Tilidine	9750
<i>/DDD/FFF</i> . Trimeperidine	9646

2. Opium derivatives. Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Acetorphine	9319
B. Acetyldihydrocodeine	9051
C. Benzylmorphine	9052
D. Codeine methylbromide	9070
E. Codeine-N-Oxide	9053
F. Cyprenorphine	9054
G. Desomorphine	9055
H. Dihydromorphine	9145
I. Drotebanol	9335
J. Etorphine (except hydrochloride salt)	9056
K. Heroin	9200
L. Hydromorphanol	9301
M. Methyldesorphine	9302
N. Methylhydromorphine	9304
O. Morphine methylbromide	9305
P. Morphine methylsulfonate	9306
Q. Morphine-N-Oxide	9307
R. Myrophine	9308
S. Nicocodeine	9309
T. Nicomorphine	9312
U. Normorphine	9313
V. Pholcodine	9314
W. Thebacon	9315

3. Opiate similar synthetic substances. Substances scheduled by the United States Drug Enforcement Administration as substances that share a pharmacological profile similar to fentanyl, morphine, and other synthetic opioids, unless specifically excepted or unless listed in another schedule. These substances are:

A. Butyryl fentanyl ( <i>N</i> -(1-phenethylpiperidin-4-yl)- <i>N</i> -phenylbutyramide)	9822
B. U-47700 (3,4-Dichloro- <i>N</i> -[2-(dimethylamino)cyclohexyl]- <i>N</i> -methyl benzamide)	9547

*/3./4.* Hallucinogenic substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances or which contains any of its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (For purposes of paragraph (1)(A)*/3./4.* of this rule only, the term isomer includes the optical, position and geometric isomers.):

A. Alpha-ethyltryptamine	7249
Some trade or other names: etryptamine; Monase; alpha-ethyl-1/ <i>H/H</i> -indole-3-ethenamine; 3-(2-aminobutyl)indole; alpha-ET; and AET;	
B. 4-bromo-2,5-dimethoxyamphetamine	7391
Some trade or other names: 4-bromo-2, 5-dimethoxy-amethylphenethylamine; 4-bromo-2, 5-DMA;	
C. 4-bromo-2,5-dimethoxyphenethylamine	7392
D. 2,5-dimethoxyamphetamine	7396
Some trade or other names: 2,5-dimethoxy-amethylphenethylamine; 2,5-DMA;	
E. 2,5-dimethoxy-4-ethylamphetamine	7399
Some trade or other names: DOET;	
F. 2,5-dimethoxy-4-(n)-propylthiophenethylamine	7348
<i>/o/Other name: 2C-T-7/</i> ;	

G. 2-(2,5-Dimethoxy-4-(n)-propylphenyl) ethanamine (2C-P)	7524
H. 2-(2,5-Dimethoxy-4-ethylphenyl) ethanamine (2C-E)	7509
I. 2-(2,5-Dimethoxy-4-methylphenyl) ethanamine (2C-D)	7508
J. 2-(2,5-Dimethoxy-4-nitro-phenyl) ethanamine (2C-N)	7521
K. 2-(2,5-Dimethoxyphenyl) ethanamine (2C-H)	7517
L. 2-(4-Chloro-2,5-dimethoxyphenyl) ethanamine (2C-C)	7519
M. 2-(4-Ethylthio-2,5-dimethoxyphenyl) ethanamine (2C-T-2)	7385
N. 2-(4-Iodo-2,5-dimethoxyphenyl) ethanamine (2C-I)	7518
O. 2-(4-Isopropylthio)-2,5-dimethoxyphenyl) ethanamine (2C-T-4)	7532
P. 4-methoxyamphetamine	7411
Some trade or other names: 4-methoxy-amethylphenethylamine; paramethoxyamphetamine; PMA;	
Q. 5-methoxy-3,4-methylenedioxyamphetamine	7401
R. 4-methyl-2,5-dimethoxyamphetamine	7395
Some trade and other names: 4-methyl-2, 5-dimethoxy-amethylphenethylamine; DOM; and STP;	
S. 3,4-methylenedioxyamphetamine	7400
T. 3,4-methylenedioxy-metham-phetamine (MDMA)	7405
U. 3,4-methylenedioxy- <i>/N/N</i> -ethylamphetamine (also known as <i>/N/N</i> -ethylalpha-methyl-3,4 (methylenedioxy) phenethylamine, <i>/N/N</i> -ethyl MDA, MDE, and MDEA)	7404
V. <i>N</i> -hydroxy-3,4-methylenedioxyamphetamine (also known as <i>/N/N</i> -hydroxy-alpha-methyl-3,4 (methylenedioxy) phenethylamine and <i>/N/N</i> -hydroxy MDA)	7402
W. 3,4,5-trimethoxyamphetamine	7390
X. 5-MeO-DMT or 5-methoxy- <i>/N/N,N,N,N</i> -dimethyltryptamine	7431
Y. Alpha-methyltryptamine	7432
Z. Bufotenine	7433
Some trade and other names: 3-(b-Dimethylaminoethyl)-5-hydroxy-indole; 3-(2-dimethylaminoethyl)-5-indolol; <i>/N/N,N,N,N</i> -dimethylserotonin; 5-hydroxy- <i>/N/N,N,N,N</i> -dimethyltryptamine; map-pine;	
AA. Diethyltryptamine	7434
Some trade and other names: <i>/N/N,N,N,N</i> -Diethyltryptamine; DET;	
BB. Dimethyltryptamine	7435
Some trade or other names: DMT;	
CC. 5-methoxy- <i>/N/N,N,N,N</i> -diisopropyltryptamine (other name: 5-MeO-DIPT)	7439
DD. Ibogaine	7260
Some trade and other names: 7-Ethyl-6,6β,7,8,9,10,12,13-octahydro-2-methoxy-6, 9-methano-5/ <i>H/H</i> -pyrido [1',2':1,2] azepino [5,4-b] indole; Tabernanthe iboga;	
EE. Lysergic acid diethylamide	7315
FF. Marihuana	7360
Some trade or other names: marijuana;	
GG. Mescaline	7381
HH. Parahexyl	7374
Some trade or other names: 3-Hexyl-1-hydroxy-7,8,9,10-tetrahydro-6,6,9-trimethyl-6/ <i>H/H</i> -dibenzo[b,d]pyran; Synhexyl;	
II. Peyote	7415
Meaning all parts of the plant presently classified botanically as <i>Lophophora williamsii</i> Lemaire, whether growing or not; the seeds thereof; any extract from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds, or extracts;	
JJ. <i>/N/N,N,N,N</i> -ethyl-3-piperidyl benzilate	7482
KK. <i>/N/N,N,N,N</i> -methyl-3-piperidyl benzilate	7484
LL. Psilocybin	7437

MM. Psilocyn 7438

NN. Tetrahydrocannabinols naturally contained in a plant of the genus Cannabis (cannabis 7370 plant), as well as synthetic equivalents of the substances contained in the cannabis plant or in the resinous extractives of such plant, and/or synthetic substances, derivatives and their isomers, or both, with similar chemical structure and pharmacological activity to those substances contained in the plant, such as the following:

(I) 1 cis or trans tetrahydrocannabinol and their optical isomers;

(II) 6 cis or trans tetrahydrocannabinol and their optical isomers;

(III) 3,4 cis or trans tetrahydrocannabinol and its optical isomers; and

(IV) Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions are covered./.;

OO. Ethylamine analog of phencyclidine 7455

Some trade or other names: /N/N-ethyl-1-phenylcyclohexylamine, (1-phenylcyclohexyl) ethylamine, /N/N-(1-phenylcyclohexyl)-ethylamine, cyclohexamine, PCE;

PP. Pyrrolidine analog of phencyclidine 7458

Some trade or other names: 1-(1-phenylcyclohexyl)-pyrrolidine PCPy, PHP;

QQ. Thiophene analog of phencyclidine 7470

Some trade or other names: 1-(1-(2-thienyl)-cyclohexyl)-piperidine, 2-thienyl analog of phencyclidine, TPCP, TCP;

RR. 1-(1-(2-thienyl)cyclohexyl) pyrrolidine 7473

Some other names: TCPy./.;

SS. Salvia divinorum;

TT. Salvinorin A;

UU. Synthetic cannabinoids: Unless specifically exempted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, or which contains their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(I) Any compound structurally derived from 3-(1-naphthoyl)indole or 1/*H/H*-indol-3-yl-(1-naphthyl)methane by substitution at the nitrogen atom of the indole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/N/N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent, whether or not substituted in the naphthyl ring to any extent. Including, but not limited to:

(a) AM2201, or 1-(5-fluoropentyl)-3-(1-naphthoyl)indole 7201

(b) JWH-007, or 1-pentyl-2-methyl-3-(1-naphthoyl)indole

(c) JWH-015, or 1-propyl-2-methyl-3-(1-naphthoyl)indole

(d) JWH-018, or 1-pentyl-3-(1-naphthoyl)indole 7118

(e) JWH-019, or 1-hexyl-3-(1-naphthoyl)indole 7019

(f) JWH-073, or 1-butyl-3-(1-naphthoyl)indole 7173

(g) JWH-081, or 1-pentyl-3-(4-methoxy-1-naphthoyl)indole 7081

(h) JWH-098, or 1-pentyl-2-methyl-3-(4-methoxy-1-naphthoyl)indole

(i) JWH-122, or 1-pentyl-3-(4-methyl-1-naphthoyl)indole 7122

(j) JWH-164, or 1-pentyl-3-(7-methoxy-1-naphthoyl)indole

(k) JWH-200, or 1-(2-(4-(morpholinyl)ethyl))-3-(1-naphthoyl)indole 7200

(l) JWH-210, or 1-pentyl-3-(4-ethyl-1-naphthoyl)indole

(m) JWH-398, or 1-pentyl-3-(4-chloro-1-naphthoyl)indole 7398

(II) Any compound structurally derived from 3-(1-naph-

thoyl)pyrrole by substitution at the nitrogen atom of the pyrrole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/N/N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the pyrrole ring to any extent, whether or not substituted in the naphthyl ring to any extent;

(III) Any compound structurally derived from 1-(1-naphthylmethyl)indene by substitution at the 3-position of the indene ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/N/N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent;

(IV) Any compound structurally derived from 3-phenylacetylindole by substitution at the nitrogen atom of the indole ring with alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/N/N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Including, but not limited to:

(a) JWH-201, or 1-pentyl-3-(4-methoxyphenylacetyl)indole

(b) JWH-203, or 1-pentyl-3-(2-chlorophenylacetyl)indole 7203

(c) JWH-250, or 1-pentyl-3-(2-methoxyphenylacetyl)indole 6250

(d) JWH-251, or 1-pentyl-3-(2-methylphenylacetyl)indole

(e) RCS-8, or 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole 7008

(V) Any compound structurally derived from 2-(3-hydroxycyclohexyl)phenol by substitution at the 5-position of the phenolic ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/N/N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not substituted in the cyclohexyl ring to any extent. Including, but not limited to:

(a) CP 47,497 & homologues, or 2-[(1R,3S)-3-hydroxycyclohexyl]-5-(2-methyloctan-2-yl)phenol, where side chain n=5, and homologues where side chain n-4,6, or 7; 7297, 7298

(VI) Any compound containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/N/N-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Including, but not limited to:

(a) AM-694, or 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole 7694

(b) RCS-4, or 1-pentyl-3-(4-methoxybenzoyl)indole (SR-19 and RCS-4) 7104

(VII) CP 50,556-1, or [(6S,6aR,9R,10aR)-9-hydroxy-6-methyl-3-[(2R)-5-phenylpentan-2-yl]oxy-5,6,6a,7,8,9,10,10a-octahydrophenanthridin-1-yl] acetate;

(VIII) HU-210, or (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol;

(IX) HU-211, or Dexanabinol, (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol; **and**

(X) Dimethylheptylpyran, or DMHP.

/4./5. Depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Gamma-hydroxybutyric acid and other names GHB; gamma-hydroxybutyrate; 4-hydroxybutyrate; 4-hydroxybutonic acid; sodium oxybate; sodium oxybutyrate; 2010

B. Mecloqualone 2572



C. Methaqualone	2565	(Other names: 25I-NBOMe; 2C-I-NBOMe; 25I; Cimbi-5)	7538
[5.]6. Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers:			
A. Aminorex	1585	E. 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25C-NBOMe; 2C-C-NBOMe; 25C; Cimbi-82)	7537
Some trade or other names: aminoxaphen; 2-amino-5-phenyl-2-oxazolone; 4,5-dihydro-5-phenyl-2-oxazolamine;			
B. [N/N]-benzylpiperazine	7493	F. 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25B-NBOMe; 2C-B-NBOMe; 25B; Cimbi-36)	7536
[s/Some other names: BZP, 1-benzylpiperazine];			
C. Cathinone	1235	G. 4-methyl-N-ethylcathinone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-MEC; 2-(ethylamino)-1-(4-methylphenyl)propan-1-one)	1249
[Some trade or other names: 2-amino-1-phenyl-1-propanone, alphaaminopropiophenone, 2-aminopropiophenone and norephedrone];			
D. Fenethylamine	1503	H. 4-methyl-alpha-pyrrolidinopropiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-MePPP; MePPP; 4-methyl-alpha-pyrrolidinopropiophenone; 1-(4-methylphenyl)-2-(pyrrolidin-1-yl)-propan-1-one)	7498
E. 3-Fluoromethcathinone	1233	I. alpha-pyrrolidinopentiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: alpha-PVP; alpha-pyrrolidinovaleerophenone; 1-phenyl-2-(pyrrolidin-1-yl)pentan-1-one)	7545
F. 4-Fluoromethcathinone	1238	J. Butylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: bk-MBDB; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one)	7541
G. Mephedrone, or 4-methylmethcathinone	1248	K. Pentedrone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: alpha-methylaminovaleerophenone; 2-(methylamino)-1-phenylpentan-1-one)	1246
H. Methcathinone	1237	L. Pentylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: bk-MBDP; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one)	7542
Some trade or other names: 2-(methylamino)-propiofenone; alpha-(methylamino) propiophenone; 2-(methylamino)-1-phenylpropan-1-one; alpha-[N/N]-methylaminopropiophenone; monomethylpropion; ephedrone; [N/N]-methylcathinone; methylcathinine; AL-464; AL-422; AL-463; and URI 432;			
I. 4-methoxymethcathinone		M. Naphyrone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: naphthylpyrovalerone; 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one)	1258
J. cis-4-methylaminorex (cis-4,5-dihydro-4-methyl-5-phenyl-2-oxazolamine)	1590	N. alpha-pyrrolidinobutiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: alpha-PBP; 1-phenyl-2-(pyrrolidin-1-yl)butan-1-one)	7546
K. Methylenedioxypyrovalerone, MDPV, or (1-(1,3-Benzodioxol-5-yl)-2-(1-pyrrolidinyl)-1-pentanone	7535	O. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: AB-CHMINACA)	7031
L. Methylone, or 3,4-Methylenedioxymethcathinone	7540	P. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: AB-PINACA)	7023
M. 4-Methyl-alpha-pyrrolidinobutiophenone, or MPBP		Q. [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl)methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: THJ-2201)	7024
N. [N/N]-ethylamphetamine	1475	[R. N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: butyryl fentanyl)]	9822]
O. [N/N],[N/N]-dimethylamphetamine	1480	[S.]R. N-[1-[2-hydroxy-2-(thiophen-2-yl)ethyl]piperidin-4-yl]-N-phenylpropionamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: beta-hydroxythiofentanyl)	9836
[s/Some other names: [N/N],[N/N]-alpha-trimethylbenzeneethanamine; N,N-alpha-trimethylphenethylamine];			
P. Quinolin-8-yl 1-pentyl-1H-indole-3-carboxylate (PB-22; QUPIC)	7222		
Q. Quinolin-8-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate (5-fluoro-PB-22; 5F-PB-22)	7225		
R. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide (AB-FUBINACA)	7012		
S. N-(1-amino-3, 3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide (ADB-PINACA)	7035		
[6.]7. A temporary listing of substances subject to emergency scheduling under federal law shall include any material, compound, mixture, or preparation which contains any quantity of the following substances:			
A. (1-pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl) methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: UR-144, 1-pentyl-3-(2,2,3,3-tetramethylcyclopropyl)indole)	7144		
B. [1-(5-fluoro-pentyl)-1H-indol-3-yl](2,2,3,3-tetramethylcyclopropyl) methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5-fluoro-UR-144, 5-F-UR-144, XLR11, 1-(5-fluoro-pentyl)-3-(2,2,3,3-tetramethylcyclopropyl)indole)	7011		
C. N-(1-adamantyl)-1-pentyl-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomer (Other names: APINACA, AKB48)	7048		
D. 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers			

- ITJS.* *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: acetyl fentanyl) 9821
- IUJT.* *N*-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MAB-CHMINACA; ADB-CHMINACA) 7032
- IV.* 3, 4-dichloro-*N*-[2-(dimethylamino)cyclohexyl]-*N*-methylbenzamide (Other names: U-47700) 95471
- IWJU.* *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylfuran-2-carboxamide (Other names: furanyl fentanyl) 9834
- V.** methyl 2-(1-(5-fluoropentyl)-1*H*-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-ADB; 5F-MDMB-PINACA) (7034)
- W.** methyl 2-(1-(5-fluoropentyl)-1*H*-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-AMB) (7033)
- X.** *N*-(adamantan-1-yl)-1-(5-fluoropentyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-APINACA, 5F-AKB48) (7049)
- Y.** *N*-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: ADB-FUBINACA) (7010)
- Z.** methyl 2-(1-(cyclohexylmethyl)-1*H*-indole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MDMB-CHMICA, MMB-CHMINACA) (7042)
- AA.** methyl 2-(1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MDMB-FUBINACA) (7020)
- BB.** *N*-(4-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: 4-fluoroisobutyryl fentanyl, *para*-fluoroisobutyryl fentanyl) (9824)
- CC.** *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacrylamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: acryl fentanyl, acryloylfentanyl) (9811)
- DD.** *N*-(2-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl)propionamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: *ortho*-fluorofentanyl, 2-fluorofentanyl) (9816)
- EE.** *N*-(1-phenethylpiperidin-4-yl)-*N*-phenyltetrahydrofuran-2-carboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: tetrahydrofuran fentanyl) (9843)
- FF.** 2-methoxy-*N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: methoxyacetyl fentanyl) (9825)
- GG.** methyl 2-(1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: FUB-AMB, MMB-FUBINACA, AMB-FUBINACA) (7021)
- HH.** *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylcyclopropanecarboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: cyclopropyl fentanyl) (9845)
- II.** *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylpentanamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: valeryl fentanyl) (9804)
- JJ.** *N*-(4-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl) butyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-fluorobutyryl fentanyl) (9823)
- KK.** *N*-(4-methoxyphenyl)-*N*-(1-phenethylpiperidin-4-yl)butyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-methoxybutyryl fentanyl) (9837)
- LL.** *N*-(4-chlorophenyl)-*N*-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-chloroisobutyryl fentanyl) (9826)
- MM.** *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylisobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: isobutyryl fentanyl) (9827)
- NN.** *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylcyclopentanecarboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: cyclopentyl fentanyl) (9847)
- OO.** *N*-(2-fluorophenyl)-2-methoxy-*N*-(1-phenethylpiperidin-4-yl)acetamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: ocfentanyl) (9832)
- PP.** Fentanyl-related substances, their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers. 9850
- (I) Fentanyl-related substance means any substance not otherwise listed under another Administration Controlled Substance Code Number, and for which no exemption or approval is in effect under section 505 of the Federal Food, Drug, and Cosmetic Act 21 U.S.C. 355, that is structurally related to fentanyl by one or more of the following modifications:
- (a) Replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;
- (b) Substitution in or on the phenethyl group with alkyl, alkenyl, alkoxy, hydroxyl, halo, haloalkyl, amino, or nitro groups;
- (c) Substitution in or on the piperidine ring with alkyl, alkenyl, alkoxy, ester, ether, hydroxyl, halo, haloalkyl, amino, or nitro groups;
- (d) Replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; and/or
- (e) Replacement of the *N*-propionyl group by another acyl group;
- QQ.** Naphthalen-1-yl 1-(5-fluoropentyl)-1*H*-indole-3-carboxylate, its optical, positional, and geometric isomers, salts, and salts of isomers

- (Other names: NM2201; CBL2201) (7221)  
**RR.** *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-AB-PINACA) (7025)  
**SS.** 1-(4-cyanobutyl)-*N*-(2-phenylpropan-2-yl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-CN-CUMYL-BUTINACA; 4-cyano-CUMYL-BUTINACA; 4-CN-CUMYLBINACA; CUMYL-4CN-BINACA; SGT-78) (7089)  
**TT.** methyl 2-(1-(cyclohexylmethyl)-1*H*-indole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MMB-CHMICA, AMB-CHMICA) (7044)  
**UU.** 1-(5-fluoropentyl)-*N*-(2-phenylpropan-2-yl)-1*H*-pyrrolo[2,3-*b*]pyridine-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-CUMYL-P7AICA) (7085)  
**VV.** *N*-Ethylpentylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: ephylone, 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one) (7543)

[7.]8. Khat, to include all parts of the plant presently classified botanically as *catha edulis*, whether growing or not; the seeds thereof; any extract from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seed, or extracts. 7032

(B) Schedule II shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section. Each drug or substance has been assigned the Controlled Substances Code Number set forth opposite it.

1. Substances, vegetable origin, or chemical synthesis. Unless specifically excepted or unless listed in another schedule, Schedule II shall include any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

A. Opium and opiate; and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, thebaine-derived butorphanol, dextrophan, nalbuphine, nalmefene, naloxegol, naloxone, and naltrexone and their respective salts, but including the following:

- (I) Raw opium 9600
- (II) Opium extracts 9610
- (III) Opium fluid 9620
- (IV) Powdered opium 9639
- (V) Granulated opium 9640
- (VI) Tincture of opium 9630
- (VII) Codeine 9050
- (VIII) Dihydroetorphine 9334
- (IX) Ethylmorphine 9190
- (X) Etorphine hydrochloride 9059
- (XI) Hydrocodone 9193
- (XII) Hydromorphone 9150
- (XIII) Metopon 9260
- (XIV) Morphine 9300
- (XV) Oripavine 9330
- (XVI) Oxycodone 9143
- (XVII) Oxymorphone 9652
- (XVIII) Thebaine 9333

B. Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subparagraph (1)(B)1.A. of this rule shall be included

in Schedule II, except that these substances shall not include the isoquinoline alkaloids of opium;

C. Opium poppy and poppy straw[.]; 9650

D. Coca leaves (9040) and any salt, compound, derivative, or preparation of coca leaves (including cocaine (9041) and ecgonine (9180) and their salts, isomers, derivatives, and salts of isomers and derivatives), and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include:

(I) Decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine; or

(II) Ioflupane[.];

E. Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid, or powder form which contains the phenanthrene alkaloids of the opium poppy) 9670

2. Opiates. Unless specifically excepted or unless in another schedule any of the following opiates, including its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation, dextrophan, and levopropoxyphene excepted:

- A. Alfentanil 9737
- B. Alphaprodine 9010
- C. Anileridine 9020
- D. Bezitramide 9800
- E. Bulk Dextropropoxyphene (Non-dosage Forms) 9273
- F. Carfentanil 9743
- G. Dihydrocodeine 9120
- H. Diphenoxylate 9170
- I. Fentanyl 9801
- J. Isomethadone 9226
- K. Levo-alphaacetylmethadol 9220

Some other names: levo-alphaacetylmethadol, levomethadyl acetate, LAAM 9648

- L. Levomethorphan 9210
- M. Levorphanol 9220
- N. Metazocine 9240
- O. Methadone 9250
- P. Methadone-Intermediate, 4-cyano-2-dimethylamino-4,4-diphenyl butane 9254
- Q. Moramide-Intermediate, 2-methyl-3-morpholino-1,1-diphenylpropane-carboxylic acid 9802
- R. Pethidine (Meperidine) 9230
- S. Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine 9232
- T. Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate 9233
- U. Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid 9234
- V. Phenazocine 9715
- W. Piminodine 9730
- X. Racemethorphan 9732
- Y. Racemorphan 9733
- Z. Remifentanil 9739
- AA. Sufentanil 9740
- BB. Tapentadol 9780
- CC. Thiafentanil 9729

3. Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

- A. Amphetamine, its salts, optical isomers, and salts of its optical isomers 1100
- B. Lisdexamphetamine, its salts, isomers, and salts of its isomers 1205
- C. Methamphetamine, its salts, isomers, and salts of its isomers 1105
- D. Phenmetrazine and its salts 1631
- E. Methylphenidate 1724

4. Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

- A. Amobarbital 2125
- B. Glutethimide 2550
- C. Pentobarbital 2270
- D. Phencyclidine 7471
- E. Secobarbital 2315

5. Hallucinogenic substances:

- A. Nabilone 7379

Another name for nabilone: ( $\pm$ )trans-3-(1, 1-dimethylheptyl)-6, 6a,7,8,10,10a-hexahydro-1-hydroxy-6, 6-dimethyl-9H-dibenzo(b,d)pyran-9-one.

**B. Dronabinol [(-)-delta-9-trans tetrahydrocannabinol] in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration. (7365)**

6. Immediate precursors. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances:

A. Immediate precursor to amphetamine and methamphetamine:

- (I) Phenylacetone 8501

Some trade or other names: phenyl-2- propanone; P2P; benzyl methyl ketone; methyl benzyl ketone;

B. Immediate precursors to phencyclidine (PCP):

- (I) 1-phenylcyclohexylamine 7460
- (II) 1-piperidinocyclo-hexanecarbonitrile (PCC) 8603

C. Immediate precursor to fentanyl:

- (I) 4-anilino-N-phenethyl-4-piperidine (ANPP) 8333

7. Any material, compound, mixture, or preparation which contains any quantity of the following alkyl nitrites:

- A. Amyl nitrite;
- B. Butyl nitrite.

(E) Schedule V shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this subsection.

1. Narcotic drugs containing nonnarcotic active medicinal ingredients. Any compound, mixture, or preparation containing any of the following narcotic drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities as follows, which shall include one (1) or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

A. Not more than two hundred milligrams (200 mg) of codeine per one hundred milliliters (100 mL) or per one hundred grams (100 g);

B. Not more than one hundred milligrams (100 mg) of dihydrocodeine per one hundred milliliters (100 mL) or per one hundred grams (100 g);

C. Not more than one hundred milligrams (100 mg) of ethylmorphine per one hundred milliliters (100 mL) or per one hundred grams (100 g)/.;

D. Not more than two and five-tenths milligrams (2.5 mg) of diphenoxylate and not less than twenty-five micrograms (25 mcg) of atropine sulfate per dosage unit/./;

E. Not more than one hundred milligrams (100 mg) of opium per one hundred milliliters (100 mL) or per one hundred grams (100 g)/./; and

F. Not more than five-tenths milligram (0.5 mg) of difenoxin (DEA Drug Code No. 9168) and not less than twenty-five micrograms (25 mcg) of atropine sulfate per dosage unit.

2. Stimulants. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture,

or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system including its salts, isomers, and salts of isomers:

- A. Pyrovalerone 1485

3. Any compound, mixture, or preparation containing any detectable quantity of pseudoephedrine or its salts or optical isomers, or salts of optical isomers or any compound, mixture, or preparation containing any detectable quantity of ephedrine or its salts or optical isomers, or salts of optical isomers if the drug preparations are starch-based solid dose forms, if such preparations are sold over the counter without a prescription. The following drug preparations containing ephedrine and pseudoephedrine are not scheduled controlled substances:

- A. Drug preparations in liquid form;

B. Drug preparations that require a prescription in order to be dispensed.

4. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts:

- A. Ezogabine [*N*-[2-amino-4-(4- fluorobenzylamino)-phenyl]-carbamic acid ethyl ester] 2779

- B. Lacosamide [(*R*)-2-acetoamido-*N*-benzyl-3-methoxy-propionamide] 2746

- C. Pregabalin [(*S*)-3-(aminomethyl)-5-methylhexanoic acid] 2782

- D. Brivaracetam ((2*S*)-2-[(4*R*)-2-oxo-4-propylpyrrolidin-1-yl]butanamide) (also referred to as BRV; UCB-34714; Briviact) 2710

**5. Approved cannabidiol drugs.**

- A. **A drug product in finished dosage formulation that has been approved by the U.S. Food and Drug Administration that contains cannabidiol (2-[1*R*-3-methyl-6*R*-(1-methylethenyl)-2-cyclohexen-1-yl]-5-pentyl-1,3-benzenediol) derived from cannabis and no more than one tenth percent (0.1%) (w/w) residual tetrahydrocannabinols** 7367

*AUTHORITY: sections 195.015 and 195.195, RSMo 2016. Material found in this rule previously filed as 19 CSR 30-1.010. Original rule filed April 14, 2000, effective Nov. 30, 2000. Amended: Filed Jan. 31, 2003, effective July 30, 2003. Amended: Filed Sept. 30, 2016, effective May 30, 2017. Emergency amendment filed Oct. 25, 2018, effective Nov. 4, 2018, expires May 2, 2019. 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 1—General Organization

### EMERGENCY RULE

#### 22 CSR 10-1.030 Board of Trustees Election Process

*PURPOSE: This rule establishes the policy of the board of trustees in regard to election of board members by the subscribers of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of*

*confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency 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. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) The subscribers of the Missouri Consolidated Health Care Plan (MCHCP) shall elect two (2) active employee members and one (1) retiree member to the board of trustees. Each member will serve a term of four (4) years from the first day of January following their election.

(2) Board Member Candidate Eligibility.

(A) Candidates must be a subscriber of the plan.

(B) A candidate who is running for a position on the board as an active employee member must be employed on the date the nominating petitions are due. Failure to be employed at that time will result in an automatic disqualification.

(C) A candidate who is running for a position on the board as a retiree member must be retired on the date that the nominating petitions are due. Failure to be retired at that time will result in an automatic disqualification.

(D) The following members are not eligible candidates:

1. Current employees of the plan;
2. Immediate relatives of persons employed by the plan.

Immediate relatives include:

- A. Employee's spouse;
- B. Children of employee or spouse;
- C. Parents of employee or spouse;
- D. Brothers and sisters of employee, including brothers-in-law and sisters-in-law;
- E. Grandchildren (including great-grandchildren) of employee or spouse;
- F. Grandparents (including great-grandparents) of employee or spouse; and
- G. Members of the employee's household.

(E) It will be automatic grounds for disqualification if it is determined that a candidate knowingly submitted false information in the election process.

(3) Nomination Process.

(A) Candidates will be nominated by means of a nominating petition.

(B) The plan will notify subscribers of an opening for a board position.

(C) Candidates may only run for one (1) position on the board.

(D) Candidates must download from MCHCP's website, complete, and submit in a manner indicated by the plan, a valid nominating petition by a date determined by the plan. Valid nominating petitions include:

1. Candidate Information, including but not limited to, name, department, and resume;

2. Information to solicit the candidate's interest in health care issues;

3. Information to solicit any disqualifying information of the candidate;

4. A summary of information regarding the candidate's background and qualifications, for example: years of state service, department experience, and reasons for wanting to be on the board. The summary shall not exceed three hundred (300) words and will be used on the voting website. Formatting of this information for the board election ballot materials will be under the direction of the plan; and

5. Any additional information as determined by the plan which is important to the nominating and voting process.

(E) Board member candidates may not use state resources (equipment, personnel, and supplies) for campaign purposes. Board member candidates may not use interagency mail or send email from a computer provided by the state to distribute campaign materials. State agencies, at their discretion, may allow the posting of campaign materials provided by the candidates on an equal time basis.

(F) Board candidates may not use the plan's resources for campaign purposes. This includes receiving demographic information of the plan's members, including but not limited to, member names, phone numbers, addresses, and email addresses.

(G) The plan will establish procedures to ensure candidate information is true and accurate. These procedures will include, but may not be limited to, validation of the information on the candidate petition forms.

(H) If only one (1) valid nominating petition is filed for any vacancy, the person nominated will be declared elected by the board at the next regular board meeting.

(I) If at least one (1) valid nominating petition is not filed for each vacancy to be filled, this election process shall be repeated for that vacancy until a valid nominating petition is received.

(4) Election Ballots and Results.

(A) The plan will notify members of an election voting period in advance of the start of the voting period in the year of the board election.

(B) The voting period will be at least fourteen (14) calendar days in length. The beginning date of the voting period will be set by MCHCP's Executive Director.

(C) Voters must be a subscriber of the plan as of the last day of the month preceding the month in which the election is to be held.

(D) Names of candidates will be listed on the website or in a supplemental publication in random order at the discretion of the plan. In no event will names of candidates be placed in alphabetical order on the election ballot or in a supplemental publication other than by happenstance.

(E) All board election voting will be completed through the eligible subscriber's myMCHCP account. Access to computers for voting use will be available at MCHCP during normal business hours. Ballots not submitted through a myMCHCP account are invalid. An eligible subscriber may only vote once per election.

(F) Voting will cease at midnight Missouri time on the last day of the board election.

(G) Ballots for an active employee member election will allow selection of one (1) or two (2) active employee member candidates to become board members depending on the number of positions up for election. If the election is for two (2) board positions, the two (2) candidates receiving the highest number of votes will be declared elected. If the election is for one (1) board position, the candidate receiving the highest number of votes will be declared elected. If a tie occurs between two (2) or more candidates receiving an identical number of votes, the winner shall be determined by a toss of a coin.

(H) Ballots for retiree members will allow selection for one (1) retiree member candidate to become a board member. The one (1) candidate receiving the highest number of votes will be declared

elected. If a tie occurs between two (2) or more candidates receiving an identical number of votes, the winner shall be determined by a toss of a coin.

(I) The Executive Director will administer any online balloting procedures, record all votes, and declare election results.

(J) The election results will be posted within forty-eight (48) hours of the official certification of the election by the plan. Voting records will be maintained by the Executive Director for a period of one (1) year. After one (1) year from the date of the certification of the results, voting information will be destroyed.

(K) Newly elected board members will begin their terms upon certification of the election.

(5) Qualifications for Board Members.

(A) The winning candidate(s) shall file a personal financial disclosure per RSMo, 103.008 within thirty (30) days of their election to the board.

(B) A board member representing active employee members must be employed on January 1 of each year following the election. Failure to be employed at that time will result in their resignation from the board.

(C) A board member representing active employee members who terminates employment with a covered agency for more than thirty (30) consecutive days while serving on the board will be considered to have resigned from the board. The election process will begin to fill the vacant seat within ninety (90) days of the resignation.

(D) A candidate who is running for a position on the board as a retiree member must be retired on January 1 of each year following the election. Failure to be retired at that time will result in an automatic disqualification.

(E) A retiree board member who becomes employed in a MCHCP benefit eligible position while serving on the board will be considered to have resigned from the board. The election process will begin to fill the vacant seat within ninety (90) days of the resignation.

(6) Vacancies. If a vacancy occurs at any time in the three (3) elected seats, election procedures will begin to take place within ninety (90) days of the vacancy.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 10-2.010 Definitions.** The Missouri Consolidated Health Care Plan is amending sections (19), (29), (39), (51) and (52), deleting section (74), and renumbering thereafter.

*PURPOSE: This amendment revises the definitions of diabetes education, essential benefits, Health Savings Account Plan, network, and non-network; removes the definition of terminated vested subscriber because it is duplicative of section (79); and renumbers as necessary.*

*PURPOSE: This rule establishes the 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, 2019, in accordance with the new plan year.*

*Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(19) Diabetes [Education] self-management/training. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

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

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

(39) [Health Savings Account (HSA)] High Deductible Health Plan. A health plan with a higher deductible than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

(51) Network. The [facilities,] providers, [and suppliers] the health insurer, or plan has contracted with to provide health care services to members.

(52) Non-network. The [facilities,] providers, [and suppliers] the health insurer, or plan does not contract with to provide health care services to members. Some providers may be a part of secondary provider networks recognized by the vendor for non-network benefits.

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

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

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

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

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

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

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

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

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

**EMERGENCY AMENDMENT**

**22 CSR 10-2.020 General Membership Provisions.** The Missouri Consolidated Health Care Plan is amending sections (2), (3), (5), (8), and (9).

*PURPOSE: This amendment revises eligibility requirements, enrollment procedures, voluntary cancelation of coverage requirements, enrollment of a newborn child proof of eligibility procedures, disabled dependent documentation timeframes, leave of absence form, and payment timeframes.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the general membership provisions of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan*

*Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment. The employee may elect coverage for him/herself and his/her spouse/child(ren), provided the employee and his/her spouse/child(ren) have been continuously covered for health care benefits—

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

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of persons covered) is required.

2. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

4. If the retiree's spouse is a state active employee or retiree and enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

5. If a retiree who is eligible for coverage elects not to be continuously covered for him/herself and spouse/child(ren) with MCHCP from the date first eligible, or does not apply for coverage for him/herself and spouse/child(ren) within thirty-one (31) days of his/her eligibility date, the retiree and his/her spouse/child(ren) shall not thereafter be eligible for coverage unless specified elsewhere herein.

6. An individual enrolled in another non-MCHCP **Medicare Advantage (Part C) and/or Medicare Prescription Drug Plan (Part D)** is not eligible for medical coverage.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.

B. Active Employee Coverage of a Spouse.

(I) If both spouses are active state employees covered by MCHCP, each spouse must enroll separately.

C. Retiree Coverage of a Spouse.

(I) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(II) At retirement, an employee eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may enroll as a spouse under MCHCP;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;  
 (II) Legally-adopted child of subscriber or spouse;  
 (III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) **[Newborn] Child of a dependent [or child of a dependent when paternity by the dependent is established after birth so long as the parent is a dependent on the newborn's date of birth or the date the child's paternity was established and continues to be covered as a dependent of the subscriber;] as long as the parent is a dependent on the child's date of birth. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible;**

(IX) **[Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or] Child of a dependent when paternity by the dependent is established after birth as long as the parent is a dependent on the date the child's paternity was established. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's paternity establishment date for the child of the dependent to remain eligible;**

(X) **[A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.] Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or**

(XI) **A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.**

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(G), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for

the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

### (3) Enrollment Procedures.

#### (A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at [www.sebes.mo.gov](http://www.sebes.mo.gov) or through another designated enrollment system within thirty-one (31) days of his/her hire date or the date the employer notifies the employee that s/he is an eligible variable-hour employee. If enrolling a spouse or child(ren), proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period that runs October 1 through October 31 of each year.

3. An active employee may **[apply for] elect or change** coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee **[and] or** his/her spouse/child(ren) may enroll within sixty (60) days **[if s/he involuntarily loses] due to an involuntary loss of** employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child, the active employee may enroll the child in an MCHCP plan within sixty (60) days of the court order.

#### 4. Default enrollment.

**[4./A.]** If an active employee is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the PPO **[600] 1250** Plan provided through the vendor the employee is enrolled in, effective the first day of the next calendar year.

**[A./B.]** If an active employee is enrolled in the Health Savings Account (HSA) Plan **[(formerly High Deductible Health Plan)]** and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the HSA Plan at the same level of coverage.

**[B./C.]** If an active employee is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

**[C./D.]** Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

**[5./E.]** If an active employee is enrolled in dental and/or



vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[6./5.* If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. *[If a retiree with Medicare is enrolled in the PPO 300 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 300 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]* **Default enrollment.**

*[A. If a retiree with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open*

*enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]*

**A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.**

**(I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.**

**(II) If the retiree does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.**

**B. If a retiree with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, and has dependents who are not covered by Medicare, his/her dependents without Medicare will be enrolled in the PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.**

*[B./C.* If a retiree without Medicare is enrolled in the PPO 300 Plan or PPO 600 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO *[600]* 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

*[C./D.* If a retiree **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the retiree is enrolled in** at the same level of coverage, **effective the first day of the next calendar year.**

*[(I) Retirees enrolled in the HSA Plan who become Medicare eligible or their dependents become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]*

*[D./E.* If a retiree **without Medicare** is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage, **effective the first day of the next calendar year.**

*[E. If a retiree is enrolled in the Medicare Prescription Drug Only Plan and does not complete enrollment during the open enrollment period, the retiree and his/her Medicare eligible dependents will be enrolled in the Medicare Prescription Drug Only Plan at the same level of coverage.]*

6. If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

*(C)/[.]* Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an **involuntary loss of employer-sponsored coverage** under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

### 3. Default enrollment.

**A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.**

**(I) If the terminated vested subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.**

**(II) If the terminated vested subscriber does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year.**

*[3./B. If a terminated vested subscriber without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [600] 1250 Plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year.*

*[A. If a terminated vested subscriber with Medicare is enrolled in the PPO 300 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 300 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.*

*B. If a terminated vested subscriber with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]*

C. If a terminated vested subscriber **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the terminated vested subscriber is enrolled in** effective the first day of the next calendar year, at the same level of coverage.

*[(I) Terminated vested subscribers enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]*

D. If a terminated vested subscriber **without Medicare** is

enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

*[4./E. If a terminated vested subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.*

*[5./4. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.*

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an **involuntary loss of employer-sponsored coverage** under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

### 3. Default enrollment.

**A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.**

**(I) If the long-term disability subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.**

**(II) If the long-term disability subscriber does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.**

*[3./B. If a long-term disability subscriber without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [600] 1250 Plan provided through the vendor the long-term disability subscriber is enrolled in, effective the first day of the next calendar year.*

*[A./C. If a long-term disability subscriber with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete*

enrollment during the open enrollment period **and has dependents who are not covered by Medicare**, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO **[300] 1250** Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

*[B. If a long-term disability subscriber with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]*

*[C./D. If a long-term disability subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the long-term disability subscriber is enrolled in at the same level of coverage, effective the first day of the next calendar year.*

*[(I) Long-term disability subscribers enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]*

*[D./E. If a long-term disability subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.*

*[4./F. If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.*

*[5./4. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.*

(E) Survivor Coverage.

1. A survivor must submit a survivor enrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days *[if the*

*spouse/child(ren) involuntarily loses]* due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

#### 4. Default enrollment.

A. A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

*[4./B. If a survivor without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [600] 1250 Plan provided through the vendor the survivor is enrolled in, effective the first day of the next calendar year.*

*[A./C. If a survivor with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period and has dependents who are not covered by Medicare, the survivor and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [300] 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.*

*[B. If a survivor with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]*

*[C./D. If a survivor without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the survivor is enrolled in at the same level of coverage, effective the first day of the next calendar year.*

*[(I) Survivors who are enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]*

*[D./E. If a survivor without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.*

*[5./F. If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.*

*[6./5. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is*

incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP 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 MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(A) When enrolling a newborn **child**, the *[member]* **subscriber** must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the *[member]* **subscriber** of the steps to initiate coverage. The *[member]* **subscriber** is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date.

(G) Disabled Dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the **end of the month of** the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(8) Voluntary Cancellation of Coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage; *[or]*
4. When new coverage is taken through other employment*[.]; or*
5. **When the member enrolls in Medicaid.**

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may continue participation in the plan by paying the required contributions. The employing department must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, Leave of Absence Enrollment form, and bill (if applicable) from MCHCP to continue coverage. If the completed form and payment (if applicable) are returned within *[ten (10)] fourteen (14)* days of the date of the letter, coverage will continue. The employee will be set up on direct bill unless the employee and affected dependents are transferred to the plan in which his/her spouse is enrolled.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her dependents is terminated effective the last day of the month in which the employee is employed.

3. If the employee's spouse is an active employee or retiree, the employee and any dependents may transfer to the plan in which the spouse is enrolled if the transfer is elected on the Leave of Absence Enrollment form. Transfer is effective the first of the month following the date of leave. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

4. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage with MCHCP while on leave, may re-enroll in his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave or if the employee was on leave of absence during open enrollment or while on leave of absence leave had a qualifying life event or loss of employer-sponsored coverage, the employee may change plans and add spouse/child(ren). When a leave of absence employee returns to work and MCHCP receives a state contribution for the month s/he returned, s/he will be charged the applicable active employee premium for that month. For coverage to be reinstated, the employee must submit a completed Enroll/Change/Cancel form within thirty-one (31) days of returning to work. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date.

5. If the employee chooses to maintain employee coverage but not coverage for his/her dependents, the employee is eligible to regain dependent coverage upon return to work.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-2.030 Contributions.** The Missouri Consolidated Health Care Plan is amending sections (6) and (7).

*PURPOSE: This amendment revises the Missouri Consolidated Health Care Plan contribution methodology for retiree coverage;*

removes language related to the Medicare Prescription Drug Only Plan; and renumbers as necessary.

**EMERGENCY STATEMENT:** This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(6) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward retiree coverage is based on either of the following:

(A) [It] **The contribution percentage** is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%), or in other words the retiree's years of service is capped at twenty-six (26) years. [For Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium. In addition, for Medicare retirees covering dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. For non-Medicare retirees, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership

incentive and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount the MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. The above calculations can be written by formula as follows:]

1. Medicare Retiree MCHCP contribution = (2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium) + Medicare Retiree MCHCP dependent contribution (if any);

2. Non-Medicare Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium with tobacco-free incentive and the partnership incentive + Non-Medicare Retiree MCHCP dependent contribution (if any);

3. Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium at the rate tier the retiree has selected - Retiree only PPO 600 Plan total premium)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected; or

4. Non-Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium with tobacco-free incentive and partnership incentive at the rate tier the retiree has selected - Retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected;]

#### 1. Medicare retirees.

A. For Medicare retirees, the contribution percentage is multiplied by the retiree only Medicare Advantage Plan total premium. The resulting product is the MCHCP contribution, which shall be subtracted from the Medicare Advantage total premium. The difference is the amount of the retiree contribution toward the total premium.

B. For Medicare retirees covering Medicare-eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the Medicare Advantage premium, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

C. For Medicare retirees covering non-Medicare eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the difference in premium of the retiree only Medicare Advantage Plan and the premium of the dependent portion of the PPO 1250 Plan at the rate tier the retiree has selected, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

#### 2. Non-Medicare retirees.

A. For non-Medicare retirees, the contribution percentage is multiplied by the retiree only PPO 1250 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

B. For non-Medicare retirees covering Medicare-eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the Medicare Advantage premium, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

**C. For non-Medicare retirees covering non-Medicare eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: contribution percentage multiplied by the difference in premium of the retiree only PPO 1250 Plan total premium with tobacco-free incentive and partnership incentive and the premium of the PPO 1250 Plan at the rate tier the retiree has selected, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.**

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection [(3)](6)(A) is compared to the flat dollar amount that was contributed for the same rate tier in 2002. The retiree's subsidy is the greater of the amount calculated in subsection [(3)](6)(A) or the flat dollar amount that was contributed in 2002.

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

*(A) The subsidy is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by MOSERS or PSRS multiplied by two and one half percent (2.5%), and capped at sixty-five percent (65%). The computed percentage is multiplied by the Medicare Prescription Drug Only Plan premium at the rate tier the retiree selected. The resulting product is the MCHCP contribution, which shall be subtracted from the total Medicare Prescription Drug Only Plan premium. The difference is the amount of the retiree contribution toward the Medicare Prescription Drug Only Plan premium. The above calculation can be written by formula as follows: Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Medicare Prescription Drug Only Plan premium; or*

*(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (7)(A) is compared to fifty-nine percent (59%) of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (7)(A) or fifty-nine percent (59%) of the Medicare Prescription Drug Only Plan.]*

*[(8)](7) Premium. Payroll deductions, Automated Clearing House (ACH) transactions, debit cards, credit cards, and/or direct bills are processed by MCHCP.*

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

3. If a subscriber owes premiums outside the current month, payroll deductions for all other premiums owed will be divided equally and taken from the subscriber's future payrolls as follows:

A. Fifty dollars (\$50) or less, deduction will be taken from one (1) payroll;

B. Fifty-one dollars (\$51) to one hundred dollars (\$100) will be deducted from two (2) payrolls;

C. One hundred one dollars (\$101) to two hundred dollars (\$200) will be deducted from three (3) payrolls;

D. Two hundred one dollars (\$201) to three hundred dollars (\$300) will be deducted from four (4) payrolls;

E. Three hundred one dollars (\$301) to four hundred dollars

(\$400) will be deducted from five (5) payrolls;

F. Four hundred one dollars (\$401) to five hundred dollars (\$500) will be deducted from six (6) payrolls;

G. Five hundred one dollars (\$501) to six hundred dollars (\$600) will be deducted from seven (7) payrolls;

H. Six hundred one dollars (\$601) to seven hundred dollars (\$700) will be deducted from eight (8) payrolls;

I. Seven hundred one dollars (\$701) to eight hundred dollars (\$800) will be deducted from nine (9) payrolls;

J. Eight hundred one dollars (\$801) to nine hundred dollars (\$900) will be deducted from ten (10) payrolls;

K. Nine hundred one dollars (\$901) to one thousand dollars (\$1,000) will be deducted from eleven (11) payrolls; and

L. One thousand one dollars (\$1,001) and over will be deducted from twelve (12) payrolls.

4. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(B) Active Employee Whose Payroll Information is not Housed in the SAM II Human Resource System.

1. Premium payroll deductions to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If a subscriber owes past-due premiums, payroll deductions for current premiums along with the payroll deductions for past-due premiums may be taken at the discretion of the employer.

2. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deductions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit check deduction is taken for October medical, dental, and vision premiums).

2. If a retiree or survivor is currently having deductions taken from his/her benefit check and owes past-due premiums due to a change in his/her deductions, MCHCP will contact MOSERS to determine if the benefit check is large enough to cover the past-due premiums. If the benefit check is large enough to cover the past-due premiums, deductions will be divided and taken from the retiree or survivor's next three (3) benefit checks and coverage will be continuous. If the retiree or survivor's benefit check is not large enough to cover the deductions, and the retiree or survivor has failed to make the necessary premium payments, coverage will be terminated due to nonpayment, effective the last day of the month a full premium was received.

(D) Direct Bill of Premium Owed By Subscribers Whose Premium is not Deducted from Payroll or Benefit Check.

1. Premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

2. A subscriber may elect to pay premiums by ACH electronic payment. In that case, the subscriber agrees that he/she will not receive a monthly bill.

A. Premiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental,

and vision premiums).

B. If there are insufficient funds, MCHCP will bill the subscriber for the premium owed. The due date of the premium owed shall not change due to insufficient funds.

**[(9)](8) Premium Payments.**

(A) By enrolling in coverage under MCHCP, an active employee agrees that MCHCP may deduct the member's contribution toward the total premium from the subscriber's paycheck. Payment for the first month's premium is made by payroll deduction. Subsequent premium payments are deducted from the active employee's paycheck. If the active employee's check is not sufficient to cover his/her premium, the active employee agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP.

(B) By enrolling in coverage under MCHCP, the retiree or survivor agrees that MCHCP will automatically deduct the premium from the retiree or survivor's benefit check. The retiree or survivor may choose to receive a monthly bill in lieu of an automatic deduction. If the retiree or survivor's deduction is not sufficient to cover his/her premium or the retiree or subscriber chooses to receive a monthly bill, the retiree or survivor agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP.

(C) If the subscriber fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received. The subscriber is responsible for claims submitted after the termination date.

1. If a non-Medicare subscriber fails to pay premiums by the required due date, MCHCP allows a thirty-one- (31-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, coverage will be retroactively terminated on the last day of the month for which full premium payment was received. The subscriber will be responsible for the value of the services rendered after the retroactive termination date, including, but not limited to, the grace period.

2. If a Medicare primary subscriber fails to pay premiums by the required due date, MCHCP allows a sixty- (60-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the sixty- (60-) day grace period, coverage will be terminated effective the end of month in which the sixty- (60-) day grace period ends.

**[(10)](9) Refunds of overpayments are limited to the amount overpaid during the twelve- (12-) month period ending at the end of the month preceding the month during which notice of overpayment is received by MCHCP.**

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 amending section (1).

*PURPOSE: This amendment adds preauthorization requirements for chemotherapy for cancer diagnosis, dialysis, and specialty injectibles; revises preauthorization requirements for surgery (outpatient); alphabetizes the list of medical services, and renumbers as necessary.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, *[including,] or who are enrolled in the Medicare[,] Advantage Plan* are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorization does not verify eligibility or payment. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to preauthorization:

- A. Ambulance services for non-emergent use, whether air or ground;
- B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;
- C. Applied behavior analysis for autism at initial service;
- D. Auditory brainstem implant (ABI);
- E. Bariatric surgery;
- F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;
- G. Chelation therapy;**
- H. Chemotherapy for cancer diagnosis;**
- [G./I. Chiropractic services after twenty-six (26) visits annually;*
- [H./J. Cochlear implant device;*
- [I. Chelation therapy;]*

*/J./K.* Dental care;

**L. Dialysis**

*/K./M.* Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

*/L./N.* Genetic testing or counseling;

*/M./O.* Hearing Aids;

*/N./P.* Home health care;

*/O./Q.* Hospice care and palliative services;

*/P./R.* Hospital inpatient services;

*/Q./S.* Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

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

*/S./U.* Nutritional counseling after six (6) sessions annually;

*/T./V.* Orthognathic surgery;

*/U./W.* Orthotics over one thousand dollars (\$1,000);

*/V./X.* Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per calendar year;

*/W./Y.* Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

*/X./Z.* Prostheses over one thousand dollars (\$1,000);

*/Y./AA.* Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

*/Z./BB.* Skilled nursing facility;

**CC. Specialty injectables;**

*/AA./DD.* Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, 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), **total hip arthroplasty, total knee arthroplasty,** 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); and

*/BB./EE.* Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

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

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which 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. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization 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 neces-

sary 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 ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent preauthorization 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;

*AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 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, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency 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. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Deductible—per calendar year for network: per individual, seven hundred fifty dollars (\$750); family, one thousand five hundred dollars (\$1,500) and for non-network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000).



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

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—Coinsurance amounts apply to covered services 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 eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, two thousand two hundred fifty dollars (\$2,250); family, four thousand five hundred dollars (\$4,500) and for non-network: per individual, four thousand five hundred dollars (\$4,500); family, nine thousand dollars (\$9,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

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

(A) Preventive care;

(B) Nutrition counseling;

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

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

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

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans during the plan year or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments.

(A) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(B) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

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

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior

plan year's applicable copayment, deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

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

(15) Medicare.

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

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

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

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 RULE**

**22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1250 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, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of cov-*

*erage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency 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. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Deductible—per calendar year for network: per individual, one thousand two hundred fifty dollars (\$1,250); family, two thousand five hundred dollars (\$2,500) and for non-network: per individual, two thousand five hundred dollars (\$2,500); family, five thousand dollars (\$5,000).

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

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services 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 eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, three thousand seven hundred fifty dollars (\$3,750); family, seven thousand five hundred dollars (\$7,500) and for non-network: per individual, seven thousand five hundred dollars (\$7,500); family, fifteen thousand dollars (\$15,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket

maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

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

(A) Preventive care;

(B) Nutrition counseling;

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

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

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

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

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

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars (\$25); mental

health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: the lesser of twenty dollars (\$20) or fifty percent (50%) of the total cost of services; urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(C) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

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

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

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

(15) Medicare.

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

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

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

this plan's deductible and out-of-pocket maximum expenses.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 RESCISSION**

**22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges.** This rule established 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.

*PURPOSE: This rule is being rescinded because the PPO 300 Plan will not be offered after December 31, 2018.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 RESCISSION**

**22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges.** This rule established 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.

*PURPOSE: This rule is being rescinded because the PPO 600 Plan will not be offered after December 31, 2018.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1), (3), (6), (8), (10), (11), (12), (13), (17), (18), (19), and (20); and removing section (18).

*PURPOSE: This amendment revises the HSA Plan deductible, out-of-pocket maximum and clarifies influenza vaccinations, diabetes self-management education/training, family deductible, access to payment information, deductible and out-of-pocket accumulations, maximum plan payments, HSA Plan eligibility, and Health Savings Account contributions when both spouses are state employees.*

**PURPOSE:** This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) 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, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, [four thousand dollars (\$4,000)] **three thousand three hundred dollars (\$3,300)**; family, [eight thousand dollars (\$8,000)] **six thousand six hundred dollars (\$6,600)**.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—[three thousand three hundred dollars (\$3,300)] **four thousand nine hundred fifty dollars (\$4,950)**;

2. Network out-of-pocket maximum for family—[six thousand six hundred dollars (\$6,600)] **nine thousand nine hundred dollars (\$9,900)**. Any individual family member need only incur a maximum of seven thousand nine hundred dollars (\$7,900) before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—[five thousand dollars (\$5,000)] **nine thousand nine hundred dollars (\$9,900)**; and

4. Non-network out-of-pocket maximum for family—[ten thousand dollars (\$10,000)] **nineteen thousand eight hundred dollars (\$19,800)**.

(6) Influenza [immunizations] **vaccinations** provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

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

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

(11) Each subscriber will have access to payment information of the family unit **only when authorization is granted by the adult covered dependent(s)**.

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

(13) [Usual, customary, and reasonable fee allowed] **Maximum plan payment**—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at [the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor] **one hundred ten percent (110%) of Medicare reimbursement**. Members may be held liable for the amount of the fee above the allowed amount.

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

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

[(19)](18) If an **active employee** subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber and/or his/her dependent(s) will be enrolled in the PPO [600] **1250** Plan. The subscriber may enroll in a different non-HSA Plan within thirty-one (31) days of

notice from MCHCP.

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

- (A) Drug discount card;
- (B) Accident insurance;
- (C) Disability insurance;
- (D) Dental insurance;
- (E) Vision insurance; or
- (F) Long-term care insurance.

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

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

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

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

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

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

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

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

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

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

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

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

**AUTHORITY:** sections 103.059 and 103.080.3., RSMo 2016.

*Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 (3).

*PURPOSE:* This amendment revises the names of the medical plans and clarifies the following benefits: dental care, diabetes education, dialysis, genetic counseling, infusions, injections, nutrition counseling, and preventive services; alphabetizes the list of medical benefits; and renumbers as necessary.

*EMERGENCY STATEMENT:* This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Benefit Provisions Applicable to the PPO [300] 750 Plan, PPO [600] 1250 Plan, and Health Savings Account (HSA) Plan. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(3) Covered Charges Applicable to the PPO [300] 750 Plan, PPO [600] 1250, and HSA Plan.

(E) Plan benefits for the PPO [300] 750 Plan, PPO [600] 1250, and HSA Plan are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

H. Exercise Challenge Testing for exercise-induced bronchospasm;

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

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

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

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

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

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

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

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

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

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

(1) of the following conditions are met:

- (a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;
- (b) Member has a life-threatening allergy to insect stings; or

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

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

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

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

- (a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;
- (b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or
- (c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

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

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

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

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

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

3. Applied Behavior Analysis (ABA) for Autism;

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

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

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

- (I) Roux-en-Y gastric bypass;
- (II) Sleeve gastrectomy;
- (III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);
- (IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

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

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

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

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

C. All of the following criteria have been met:

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

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

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

I. Type II diabetes;

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

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

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

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

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

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

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

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

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

*[5.]6. Bone Growth Stimulators.* Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

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

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

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

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

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

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

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

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

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

(b) Grade II or worse spondylolisthesis; or

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

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

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

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

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

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

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

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

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

A. Genetic or hereditary hemochromatosis;

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

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

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

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

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

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

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

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

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

(I) A prescribed treatment program that is expected to



result in significant therapeutic improvement over a clearly defined period of time;

- (II) The symptoms being treated;
- (III) Diagnostic procedures and results;
- (IV) Frequency, duration, and results of planned treatment modalities;

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

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

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

- (I) The member reached maximal therapeutic benefit with prior chiropractic treatment;
- (II) The member was compliant with a self-directed home-care program;
- (III) Significant therapeutic improvement is expected with continued treatment; and
- (IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

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

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

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

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

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

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

- (I) National Institutes of Health (NIH);
- (II) Centers for Disease Control and Prevention (CDC);
- (III) Agency for Health Care Research and Quality;
- (IV) Centers for Medicare & Medicaid Services (CMS);
- (V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Radiologic evidence of cochlear ossification;

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

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

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

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

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

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

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

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

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

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

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. **Treatment must be initiated within sixty (60) days of accident;** and

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

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

14. Diabetes **self-management training**//E/education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

**15. Dialysis is covered when received through a network provider;**

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

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

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

(I) Colostomy and ureterostomy bags;

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

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

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

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

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

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

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

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

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

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

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

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

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

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

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

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

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

(II) Familial cancer disorders;

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

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

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

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

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

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

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

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

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

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

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

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

**[20.]21.** Genetic testing.

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

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

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

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

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

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

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

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

**[23.]24.** Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions,

sensorineural hearing loss, and mixed hearing loss.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. A home health care visit is defined as—

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

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

(I) Homemaker or housekeeping services;

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

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

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

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

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

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

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

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

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

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

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

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

**[27.]28.** Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

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

(a) Cornea transplant;

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

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

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

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

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

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

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

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

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

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

licensing body for treatment of mental health disorders;

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

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

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

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

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

(c) A state-licensed psychologist;

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

(e) Licensed professional counselor;

**29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;**

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

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

**[29.]31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by**

an out-of-network provider are not covered;

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

**[31.]33. Nutritional counseling.** Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

**[32.]34. Nutrition therapy.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) Anteroposterior Discrepancies—

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

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

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

(II) Vertical Discrepancies—

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

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

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

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

(III) Transverse Discrepancies—

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

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

(IV) Asymmetries—

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

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

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

[36.]38. Orthotics.

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

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

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

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

I. Member is covered for AFO; and

II. Additional knee stability is required; and

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

I. The member could not be fitted with a prefabricated AFO;

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

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

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

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

(II) AFO and KAFO Not Used During Ambulation.

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

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

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

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

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

V. Contracture is interfering or expected to interfere

significantly with the patient's functional abilities; and

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

VII. Member has plantar fasciitis.

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

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

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

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

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

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

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

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

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

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

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

(I) Orthopedic footwear;

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

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

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

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

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

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

(a) Acute plantar fasciitis;

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

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

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

(g) Medial osteoarthritis of the knee;

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

(i) Neurologically impaired feet including neuroma,

tarsal tunnel syndrome, ganglionic cyst;

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

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

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

(a) Hallux valgus deformities;

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

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

(d) Structural deformities such as tarsal coalitions; or

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

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

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

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

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

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

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

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

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

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

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

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

J. Orthopedic Footwear for Diabetic Members.

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

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

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

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

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

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[37.]39. Preventive services.

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

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

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

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

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

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

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

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. [Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older] Online weight management program offered through the plan's exclusive provider arrangement;

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

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

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

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

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic

coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ( $VO_2$ max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METs); or

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

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

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

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

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

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

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

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

B. Occupational therapy must meet the following criteria:

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

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

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

C. Speech therapy.

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

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

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

(c) Meaningful improvement is expected;

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

(e) One (1) of the following:

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

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

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

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when

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

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.

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

(III) Meals—not covered.

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

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

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

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 10-2.060 PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations.** This rule established the policy of the board of trustees in regard to the PPO 300 Plan, PPO 600 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded because the PPO 300 and PPO 600 Plans will not be offered after December 31, 2018.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP*

trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rescission complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

**AUTHORITY:** sections 103.059 and 103.080.3., RSMo 2016. 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 Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 RULE**

**22 CSR 10-2.061 Plan Limitations**

**PURPOSE:** This rule establishes the policy of the board of trustees in regard to the PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

**EMERGENCY STATEMENT:** This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency 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. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055 or 22 CSR 10-2.090.

(A) Abortion—unless the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(B) Acts of war including—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(C) Alternative therapies—that are outside conventional medicine including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

(D) Assistive listening device.

(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.

(F) Athletic enhancement services and sports performance training.

(G) Autopsy.

(H) Birthing center.

(I) Blood donor expenses.

(J) Blood pressure cuffs/monitors.

(K) Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

(M) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(N) Childbirth classes.

(O) Comfort and convenience items.

(P) Cosmetic procedures.

(Q) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

(R) Dental care, including oral surgery.

(S) Devices or supplies bundled as part of a service are not separately covered.

(T) Dialysis received through a non-network provider.

(U) Educational or psychological testing unless part of a treatment program for covered services.

(V) Examinations requested by a third party.

(W) Exercise equipment.

(X) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

(Y) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(Z) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(AA) Health and athletic club membership—including costs of enrollment.

(BB) Hearing aid replacement batteries.

(CC) Home births.

(DD) Infertility treatment beyond the covered services to diagnose the condition.

(EE) Infusions received through a non-network provider.

(FF) Level of care, greater than is needed for the treatment of the illness or injury.

(GG) Long-term care.

(HH) Maxillofacial surgery.

(II) Medical care and supplies to the extent that they are payable under—

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

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

(JJ) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is



related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(KK) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

(LL) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(MM) Nocturnal enuresis alarm.

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

(OO) Non-medically necessary services.

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

(QQ) Non-reusable disposable supplies.

(RR) Online weight management programs.

(SS) Other charges as follows:

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

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

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

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

(TT) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

(UU) Physical and recreational fitness.

(VV) Private-duty nursing.

(WW) Routine foot care without the presence of systemic disease that affects lower extremities.

(XX) Services obtained at a government facility if care is provided without charge.

(YY) Sex therapy.

(ZZ) Surrogacy—pregnancy coverage is limited to plan member.

(AAA) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

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

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

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

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

E. Work hardening programs;

F. Back school;

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

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

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

2. Occupational therapy—

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

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

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

D. Occupational therapy that duplicates services already

being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

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

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

H. Driving safety/driver training; and

3. Speech or voice therapy—

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

B. School speech programs;

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

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

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

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

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

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

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

(CCC) Travel expenses.

(DDD) Vaccinations requested by third party.

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

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 10-2.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (5), and (6).

*PURPOSE: This amendment revises the names of the medical plans and clarifies general appeal provisions, the appeals process for Medicare members, and documentation requirements when submitting an appeal to add dependents.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the*

first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Claims Submissions and Initial Benefit Determinations [for Medical and Non-Medicare Primary Pharmacy Services] PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(2) General Appeal Provisions [for Medical and Non-Medicare Primary Pharmacy Services].

(3) Appeal Process for Medical and Pharmacy Determinations for PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. **Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s).** Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn or the newborn of an enrolled dependent retroactively to the date of birth if the appeal is received within three (3) months of the child's birth date[. *Valid proof of eligibility must be included with the appeal*];

(6) Medicare [Primary Pharmacy] Appeals.

(B) Appeals rights and procedures for benefits covered by the Medicare Advantage Plan are provided as regulated by the Centers for Medicare and Medicaid Services. Members may contact the Medicare Advantage Plan for additional rights and procedures.

(C) Administrative Appeals as specified in subsection (3)(B) of this rule shall follow the procedures set forth in that subsection.

*AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 10-2.080 Miscellaneous Provisions.** The Missouri Consolidated Health Care Plan is amending section (5).

*PURPOSE: This amendment revises the names of the medical plans.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(5) The PPO [300] 750 Plan, PPO [600] 1250 Plan, and Health Savings Account Plan benefits including pharmacy are self-funded by the plan. MCHCP has subrogation rights under section 376.433, RSMo for any amounts expended for these benefits.

*AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 10-2.088 Medicare Advantage Plan for Non-Active Medicare Primary Members**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medicare Advantage Plan for Non-active Medicare-primary members of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency 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. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) The medical benefit for non-Active Medicare primary members is provided through a fully-insured Group Medicare Advantage PPO Plan as regulated by the Centers for Medicare and Medicaid Services (CMS) herein after referred to as the Medicare Advantage Plan. For purposes of this rule non-Active Medicare primary members include: Medicare-eligible members who are eligible retirees, terminated vested subscribers, long-term disability subscribers, and their eligible dependents who have Medicare.

(A) Members must be enrolled in Medicare Parts A and B to be eligible for the Medicare Advantage Plan.

(B) Non-active subscribers that have Medicare and/or their dependents that have Medicare shall receive their medical benefit through the Medicare Advantage Plan.

(C) Subscribers enrolled in the Medicare Advantage Plan will choose another medical plan offered by MCHCP for their non-Medicare dependents.

(D) Beginning the first day of the month in which a non-active Medicare primary member turns sixty-five (65) years old, they shall be transferred to the Medicare Advantage Plan.

(E) A member who opts out of the Medicare Advantage Plan will lose MCHCP eligibility and will not be allowed to enroll in a medical plan at a later date unless otherwise provided for in these rules.

(2) The Medicare Advantage Plan design is defined by the vendor, including deductible, out-of-pocket maximum, and benefits covered. Benefits shall be substantially similar to the benefits offered to non-Medicare members.

(3) The Medicare Advantage Plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-2.020, and in conjunction with the rules set forth by CMS.

(4) Appeals.

(A) Appeals concerning claims and benefits are managed by the vendor in accordance with CMS rules.

(B) Administrative appeals concerning eligibility and termination are managed by MCHCP in accordance with 22 CSR 10-2.075.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment clarifies eligibility for the Pharmacy Employer Group Waiver Plan, the Part B drug benefit, and preventive drugs; updates the Medicare Part D coverage stage and the copayment amounts; and removes language regarding the Medicare Prescription Drug Only Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

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

(A) [The following Medicare primary members] **Non-active subscribers that have Medicare primary coverage and their**

**dependents that have Medicare primary coverage** enrolled in *[the PPO 300, PPO 600, or]* the Medicare *[Prescription Drug Only] Advantage* Plan shall receive their pharmacy benefit through the Medicare Prescription Drug Plan<sup>1</sup>.

*[1. Active employee members that have Medicare primary coverage and their dependents that have Medicare primary coverage; and*

*2. Retiree members that have Medicare primary coverage and their dependents that have Medicare primary coverage.]*

(B) The non-Medicare *[primary]* dependents of Medicare primary *[members]* **non-active subscribers** will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

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

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

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[three thousand seven hundred fifty dollars (\$3,750)]* **three thousand eight hundred twenty dollars (\$3,820)**, the member will pay the following copayments:

A. Preferred Formulary Generic Drugs: thirty-one- (31-) day supply has *[an eight dollar (\$8)]* **a ten dollar (\$10)** copayment; sixty- (60-) day supply has a *[sixteen dollar (\$16)]* **twenty dollar (\$20)** copayment; ninety- (90-) day supply at retail has a *[twenty-four dollar (\$24)]* **thirty dollar (\$30)** copayment; and a ninety- (90-) day supply through home delivery has a *[twenty dollar (\$20)]* **twenty-five dollar (\$25)** copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a *[thirty-five dollar (\$35)]* **forty dollar (\$40)** copayment; sixty- (60-) day supply has a *[seventy dollar (\$70)]* **an eighty (\$80) dollar** copayment; ninety- (90-) day supply at retail has a *[one hundred five dollar (\$105)]* **one hundred twenty (\$120) dollar** copayment; and a ninety- (90-) day supply through home delivery has *[an eighty-seven dollar and fifty cent (\$87.50)]* **a one hundred (\$100) dollar** copayment; and

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

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand seven hundred fifty dollars (\$3,750)]* **three thousand eight hundred twenty dollars (\$3,820)** and remain below *[five thousand dollars (\$5,000)]* **five thousand one hundred dollars (\$5,100)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars (\$5,000)]* **five thousand one hundred dollars (\$5,100)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars (\$5,000)]* **five thousand one hundred dollars (\$5,100)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[three dollar and thirty-five cent (\$3.35)]* **three dollar and forty cent (\$3.40)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or an *[eight dollar and thirty-five cent (\$8.35)]* **eight dollar and fifty cent (\$8.50)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage; **and**

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs<sup>2</sup>; and<sup>3</sup>.

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

(H) Medicare Part B Prescription Drugs **are excluded from the Medicare Prescription Drug Plan.** *[For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to a Medicare Part B contracted retail pharmacy which is in the pharmacy benefit manager (PBM) network. Medicare Part B prescriptions include, but are not limited to, the following:]*

*[1. Diabetes testing and maintenance supplies;*

*2. Respiratory agents;*

*3. Immunosuppressants; and*

*4. Oral anti-cancer medications.]*

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

*[1. Prescribed Vitamin D for all ages:*

*A. The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D<sub>2</sub> or D<sub>3</sub> per dose;*

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

*[3.]1. [Influenza v]Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and*

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

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-2.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is amending the purpose and section (1).

*PURPOSE: This amendment revises the names of the medical plans, copayments, preventive drugs, and out-of-pocket maximum.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the [PPO 300, PPO 600] PPO 750 Plan, PPO 1250 Plan, and Health Savings Account Plan of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in*

place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

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

(A) PPO [300] 750 Plan and PPO [600] 1250 Plan.

1. Network:

A. Preferred formulary generic drug copayment: [Eight dollars (\$8)] **Ten Dollars (\$10)** for up to a thirty-one- (31-) day supply; [sixteen dollars (\$16)] **twenty dollars (\$20)** for up to a sixty- (60-) day supply; and [twenty-four dollars (\$24)] **thirty dollars (\$30)** for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Preferred formulary brand drug copayment: [Thirty-five dollars (\$35)] **Forty dollars (\$40)** for up to a thirty-one- (31-) day supply; [seventy dollars (\$70)] **eighty dollars (\$80)** for up to a sixty- (60-) day supply; and [one hundred and five dollars (\$105)] **one hundred twenty dollars (\$120)** for up to a ninety- (90-) day supply for a brand drug on the formulary;

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

**D. Specialty drug copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;**

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

[E./F. Home delivery programs.

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

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2)

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

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

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

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

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

(a) Preferred formulary generic drug copayments: [Eight dollars (\$8)] **Ten dollars (\$10)** for up to a thirty-one- (31-) day supply; [sixteen dollars (\$16)] **twenty dollars (\$20)** for up to a sixty- (60-) day supply; and [twenty dollars (\$20)] **twenty-five dollars (\$25)** for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: [Thirty-five dollars (\$35)] **Forty dollars (\$40)** for up to a thirty-one- (31-) day supply; [seventy dollars (\$70)] **eighty dollars (\$80)** for up to a sixty- (60-) day supply; and [eighty-seven dollars and fifty cents (\$87.50)] **one hundred dollars (\$100)** for up to a ninety- (90-) day supply for a brand drug on the formulary;

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

**(d) Specialty drug copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply; one hundred fifty dollars (\$150) for up to sixty (60-) day supply; and two hundred twenty-five (\$225) for up to ninety- (90-) day supply for a specialty drug on the formulary;**

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

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

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

[I./J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

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

**L. Preferred select brand drugs, as determined by the PBM: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply; and**

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

*[(I)] Prescribed Vitamin D for all ages;*

*(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D<sub>2</sub> or D<sub>3</sub> per dose;*

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

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

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

*[(V)](III) Prescribed preferred diabetic test strips and lancets; and*

*[(VI)](IV) One (1) preferred glucometer.*

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

3. Out-of-pocket maximum.

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

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

C. **Network** *[/]individual—[five thousand one hundred dollars (\$5,100)] four thousand one hundred fifty dollars (\$4,150).*

D. **Network** *[F]family—[ten thousand two hundred dollars (\$10,200)] eight thousand three hundred dollars (\$8,300).*

**E. Non-network—no maximum.**

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

1. Network:

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

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

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

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

E. Home delivery programs.

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

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescrip-

tion at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

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

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

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

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

*[(I)] Prescribed Vitamin D for all ages;*

*(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D<sub>2</sub> or D<sub>3</sub> per dose;*

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

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

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

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

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

(II) One (1) preferred glucometer;

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

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

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

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

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

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

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

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

**EMERGENCY AMENDMENT**

**22 CSR 10-2.110 General Foster Parent Membership Provisions.**  
The Missouri Consolidated Health Care Plan is amending sections (2), (3), and (5).

*PURPOSE: This amendment revises foster parent eligibility requirements, enrollment procedures, enrollment of a newborn child proof of eligibility procedures, and disabled dependent documentation timeframes.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(2) Eligibility Requirements.

(B) Dependent Coverage. Eligible dependents include:

1. Spouse. If both spouses are eligible foster parents, each spouse must enroll separately;
2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

- (I) Natural child of subscriber or spouse;
- (II) Legally-adopted child of subscriber or spouse;
- (III) Child legally placed for adoption of subscriber or spouse;
- (IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;
- (V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) *[Newborn] Child of a dependent [or] as long as the parent is a dependent on the newborn's date of birth. The dependent and the child of the dependent must remain continuously covered on the plan for the child of the dependent to remain eligible;*

(IX) *[c/Child of a dependent when paternity by the dependent is established after birth [so] as long as the parent is a dependent on [the newborn's day of birth or] the date the child's paternity was established [and continues to be covered as a dependent of the subscriber] The dependent and the child of the dependent must remain continuously covered on the plan for the child of the dependent to remain eligible; or*

*[(IX)](X) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).*

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(C) may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(C) An eligible foster parent may *[apply for] elect or change* coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

1. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the eligible foster parent's responsibility to notify MCHCP of the life event;

A. If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

2. Employer-sponsored group coverage loss. An eligible foster parent *[and] or* his/her spouse/child(ren) may enroll within sixty (60) days *[if s/he involuntarily loses] due to an involuntary loss*

of employer-sponsored coverage under one (1) of the following circumstances:

- A. Employer-sponsored medical, dental, or vision plan terminates;
  - B. Eligibility for employer-sponsored coverage ends;
  - C. Employer contributions toward the premiums end; or
  - D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or
3. If an eligible foster parent or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or
  4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for covering a child, the eligible foster parent may enroll the child in an MCHCP plan within sixty (60) days of the court order; or

#### 5. Default Enrollment

*15./A.* If an eligible foster parent is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the PPO *[600]* **1250** Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year; or

*16./B.* If an eligible foster parent is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the HSA Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year;

*17./C.* If an eligible foster parent is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year; or

*18./6.* If an eligible foster parent submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the foster parent of such by mail, phone, or secure message. The foster parent must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date MCHCP notifies the foster parent, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP 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 MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(A) When enrolling a newborn **child**, the *[member]* **subscriber** must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the *[member]* **subscriber** of the steps to initiate coverage. The *[member]* **subscriber** is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof

of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date.

(E) Disabled Dependent.

1. A newly eligible foster parent may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years, may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the **end of the month** of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new foster parent and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled child's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

*AUTHORITY: sections 103.059 and 103.078, RSMo 2016. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 10-2.140 Strive for Wellness<sup>®</sup> Health Center Provisions, Charges, and Services.** The Missouri Consolidated Health Care Plan is amending sections (2) and (4).

*PURPOSE: This amendment clarifies available services and preventive services; and revises the names of the medical plans.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to*



members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(2) Available Services. The health center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:

(I) *[Immunizations]* **Vaccinations** including *[immunization for]* influenza **vaccine**;

(O) Ordinary and routine care of the nature of a visit to the *[doctor's]* **health care provider's** office; and

(4) Charges for the following services apply:

(A) Office visit—

1. For active employees enrolled in the MCHCP PPO *[300]* **750** or PPO *[600]* **1250** Plan, fifteen dollars (\$15) payable at the time of service;

2. For active employees enrolled in the Health Savings Account (HSA) Plan forty-five dollars (\$45) payable at the time of service; and

3. The office visit includes the evaluation and management of the patient and any associated laboratory services performed by the health center;

(B) Preventive *[care]* **services**—

1. For active employees enrolled in the MCHCP PPO *[300]* **750** Plan, PPO *[600]* **1250** Plan, or HSA Plan, preventive *[care is]* **services** are covered at one hundred percent (100%); and

2. Preventive *[care]* **services** shall have the same meaning as in 22 CSR 10-2.055; and

(C) Health center services are outside the MCHCP PPO *[300]* **750** Plan, PPO *[600]* **1250** Plan, and HSA Plan benefits and payments for health center services do not apply toward any associated deductible or out-of-pocket maximum.

*AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. Amended: Filed Oct. 29, 2014, effective May 30, 2015. Amended: Filed Oct. 28, 2015, effective May 30, 2016. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

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

**EMERGENCY AMENDMENT**

**22 CSR 10-3.010 Definitions.** The Missouri Consolidated Health Care Plan is amending sections (19), (28), (35), (46), (47), and (70) and renumbering as necessary.

*PURPOSE: This amendment revises the definitions of diabetes education, essential benefits, Health Savings Account Plan, network, and non-network; and removes the definition of terminated vested subscriber because it is duplicative of section (73); and renumbers as*

*necessary.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(19) Diabetes **self-management** education/**training**. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

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

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

(35) *[Health Savings Account (HSA)]* **High deductible health [P/]plan**. A health plan with a higher deductible than a traditional health plan that, when combined with an **Health Savings Account (HSA)**, provides a tax-advantaged way to help save for future medical expenses.

(46) Network. The *[facilities,]* providers*], and suppliers]* the health insurer or plan has contracted with to provide health care services to members.

(47) Non-network. The *[facilities,]* providers, *[and suppliers]* the health insurer, or plan does not contract with to provide health care services to members. Some providers may be a part of secondary provider networks recognized by the vendor for non-network benefits.

*[(70) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit through a public entity's retirement system.]*

*[(71)](70) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by*

MCHCP eligibility policies.

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

[(73)](72) Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

[(74)](73) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits through a public entity's retirement system.

[(75)](74) Waiting/probationary periods. The length of time the employer requires an employee to be employed before he or she is eligible for health insurance coverage. Public entities may set different waiting/probationary periods for different employee classifications (full-time vs. part-time).

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

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

**EMERGENCY AMENDMENT**

**22 CSR 10-3.020 General Membership Provisions.** The Missouri Consolidated Health Care Plan is amending sections (2), (3), (5), and (8).

*PURPOSE: This amendment revises public entity eligibility requirements, enrollment procedures, disabled dependent documentation timeframes, and voluntary cancellation of enrollment requirements.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency*

*amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(2) Eligibility Requirements.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. Active Employee Coverage of a Spouse.

(I) If both spouses have access to MCHCP benefits through two (2) different public entities, the employee and his/her spouse may elect to enroll in coverage separately through his/her respective employer or together through one (1) of the employers. The employee cannot have coverage through both public entities.

(II) If both spouses are employed by the same public entity with access to MCHCP benefits, the employee and spouse may elect coverage either as individuals or under the spouse (if allowed by the employer).

B. Retiree Coverage of a Spouse.

(I) A public entity retiree may enroll as a spouse under a public entity employee's coverage or elect coverage as a retiree;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) *[Newborn] Child of a dependent [or] as long as the parent is a dependent on the child's date of birth. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible;*

(IX) *[c]Child of a dependent when paternity by the dependent is established after birth [so] as long as the parent is a dependent on [the newborn's day of birth or] the date the child's paternity was established [and continues to be covered as a dependent of the subscriber] the dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible;*

[(IX)](X) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

[(X)](XI) A child under twenty-six (26) years, who is eligible for MCHCP coverage as a subscriber, may be covered as a dependent of a public entity employee.

B. A child who is twenty-six (26) years old or older and is

permanently disabled in accordance with subsection (5)(F), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

### (3) Enrollment Procedures.

#### (A) Active Employee Coverage.

1. The public entity must enroll or waive coverage for a new employee by submitting a form signed by the employee and the payroll representative within thirty-one (31) days of his/her eligibility date. A new employee's coverage begins on the first day of the month after the hire date and the applicable waiting period.

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period.

3. An active employee may *[apply for] elect or change* coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). 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 MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her spouse/child(ren) may enroll within sixty (60) days *[if s/he involuntarily loses] due to an involuntary loss of* employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child(ren), the active employee may enroll the child(ren) in an MCHCP plan within sixty (60) days of the court order; or

E. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the public entity's Human Resource Department of such by mail, phone, or secure

message. The corrected form must be submitted to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If an active employee is enrolled and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the employee and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

#### (B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a separate group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). 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 MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses] due to an involuntary loss of* employer-sponsored coverage under one (1) of the following circumstances, and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

6. If a retiree is enrolled and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the retiree and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

## (C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of 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 MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an **involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a terminated vested subscriber is enrolled and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

## (D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). 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 MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an **involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot

add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a long-term disability subscriber is enrolled and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

## (E) Survivor Coverage.

1. A survivor must submit a form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of 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 MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an **involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

5. If a survivor is enrolled and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the plan offered

by the public entity for the new year. If the public entity offers two (2) plan options, the survivor and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(5) Proof of Eligibility.

(F) Disabled dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the **end of the month of the** dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(8) Voluntary Cancellation of Coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage; *[or]*
4. When new coverage is taken through other employment*[/];* or
5. **When the member enrolls in Medicaid.**

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

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

**22 CSR 10-3.045 Plan Utilization Review Policy.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment adds preauthorization requirements for chemotherapy for cancer diagnosis, dialysis, and specialty injectibles; revises preauthorization requirements for surgery (outpatient); alphabetizes the list of medical services, and renumbers as necessary.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the*

*Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization of Services—The claims administrator must authorize some services in advance. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, including Medicare, are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorization does not verify eligibility or payment. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to preauthorization:

- A. Ambulance services for non-emergent use, whether air or ground;
- B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;
- C. Applied behavior analysis for autism at initial service;
- D. Auditory brainstem implant (ABI);
- E. Bariatric surgery;
- F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;
- G. **Chelation therapy;**
- H. **Chemotherapy for cancer diagnosis;**
- /G./I.* Chiropractic services after twenty-six (26) visits annually;
- /H./J.* Cochlear implant device;
- /I.* **Chelation therapy;**
- /J./K.* Dental care;
- L. **Dialysis;**
- /K./M.* Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;
- /L./N.* Genetic testing or counseling;
- /M./O.* Hearing Aids;
- /N./P.* Home health care;
- /O./Q.* Hospice care and palliative services;
- /P./R.* Hospital inpatient services;
- /Q./S.* Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography

(MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

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

*/S./U.* Nutritional counseling after six (6) sessions annually;

*/T./V.* Orthognathic surgery;

*/U./W.* Orthotics over one thousand dollars (\$1,000);

*/V./X.* Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per calendar year;

*/W./Y.* Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

*/X./Z.* **Prostheses over one thousand dollars (\$1,000);**

*/Y./AA.* Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

*/Z./BB.* Skilled nursing facility;

**CC. Specialty injectables;**

*/AA./DD.* Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, 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), **total hip arthroplasty, total knee arthroplasty**, 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); and

*/BB./EE.* Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

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

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which 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. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization 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 ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent preauthorization 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;

*AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For inter-*

*vening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

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

**EMERGENCY RECISSION**

**22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded because the PPO 1000 Plan will not be offered after December 31, 2018.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For inter-vening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rescission covering this same material is published in this issue of the Missouri Register.*

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

**EMERGENCY AMENDMENT**

**22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1), (3), (6), (8), (10), and (12).

*PURPOSE: This amendment revises the HSA Plan deductible, out-of-pocket maximum and clarifies influenza vaccinations, diabetes self-management education/training, family deductible, access to payment information, and maximum plan payments.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, *[four thousand dollars (\$4,000)]* **three thousand three hundred dollars (\$3,300)**; family, *[eight thousand dollars (\$8,000)]* **six thousand six hundred dollars (\$6,600)**.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—*[three thousand three hundred dollars (\$3,300)]* **four thousand nine hundred fifty dollars (\$4,950)**;

2. Network out-of-pocket maximum for family—*[six thousand six hundred dollars (\$6,600)]* **nine thousand nine hundred dollars (\$9,900)**. Any individual family member need only incur a maximum of seven thousand nine hundred dollars (\$7,900) before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—*[five thousand dollars (\$5,000)]* **nine thousand nine hundred dollars (\$9,900)**; and

4. Non-network out-of-pocket maximum for family—*[ten thousand dollars (\$10,000)]* **nineteen thousand eight hundred**

**dollars (\$19,800)**.

(6) Influenza *[immunizations]* **vaccinations** provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

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

(10) Each subscriber will have access to payment information of the family unit **only when authorization is granted by the adult covered dependent(s)**.

(12) *[Usual, customary, and reasonable fee allowed]* **Maximum plan payment**—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at *[the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor]* **one hundred ten percent (110%) of Medicare reimbursement**. Members may be held liable for the amount of the fee above the allowed amount.

*AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

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

**EMERGENCY RESCISSION**

**22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges.** This rule established 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.

*PURPOSE: This rule is being rescinded because the PPO 600 Plan will not be offered after December 31, 2018.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one method*

of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

**AUTHORITY:** section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rescission covering this same material is published in this issue of the *Missouri Register*.

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

**EMERGENCY AMENDMENT**

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

**PURPOSE:** This amendment revises the names of the medical plans and clarifies the following benefits: dental care, diabetes education, dialysis, genetic counseling, infusions, injections, nutrition counseling, and preventive services; alphabetizes the list of medical benefits; and renumbers as necessary.

**EMERGENCY STATEMENT:** This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires

June 29, 2019.

(1) Benefit Provisions Applicable to the PPO [600] 750 Plan, PPO [1000] 1250 Plan, and Health Savings Account (HSA) Plan. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(3) Covered Charges Applicable to the PPO [600] 750 Plan, PPO [1000] 1250 Plan, and HSA Plan.

(E) Plan benefits for the PPO [600] 750 Plan, PPO [1000] 1250 Plan, and HSA Plan are as follows:

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

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

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

agents);

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

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

agents);

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

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

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

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

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

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

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

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

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

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

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

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);
- (IV) Inhalant allergy; or
- (V) Specific drugs;

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

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen



response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

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

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one

(1) of the following conditions are met:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Applied Behavior Analysis (ABA) for Autism;

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

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

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

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

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

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

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

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

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

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

C. All of the following criteria have been met:

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

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

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

I. Type II diabetes;

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

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

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

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

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

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

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

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

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

**/5./6. Bone Growth Stimulators.** Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing

of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

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

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

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

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

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

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

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

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

(b) Grade II or worse spondylolisthesis; or

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

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

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

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

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

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

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

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

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

A. Genetic or hereditary hemochromatosis;

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

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

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

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

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

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

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

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

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

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

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) National Institutes of Health (NIH);

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

(III) Agency for Health Care Research and Quality;

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

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

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

center support grants; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Radiologic evidence of cochlear ossification;

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

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

(II) Member must have had an assessment by an audiologist

and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

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

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

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

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

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

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

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

13. Dental care.

A. Dental care is covered for *[treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury.]* the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. **Treatment must be initiated within sixty (60) days of accident; and**

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

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

14. Diabetes **self-management training** //E/education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

**15. Dialysis is covered when received through a network provider;**

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

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

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

(I) Colostomy and ureterostomy bags;

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

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

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

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

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

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

*[16.]17.* Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit.

Hospital and ancillary charges are paid as a network benefit;

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

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

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

- (I) Diabetes mellitus;
- (II) Peripheral vascular disease; or
- (III) Peripheral neuropathy.

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

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

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

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

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

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

(II) Familial cancer disorders;

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

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

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

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

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

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

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

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

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

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

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

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

**[20.]21.** Genetic testing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. A home health care visit is defined as—

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

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

(I) Homemaker or housekeeping services;

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

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

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

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

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

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

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

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

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

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

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

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

**[27.]28.** Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

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

(a) Cornea transplant;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A state-licensed psychologist;

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

(e) Licensed professional counselor;

**29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;**

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

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

- (XI) Megaloblastic anemia;
- (XII) Malnutrition of alcoholism;
- (XIII) Thrombocytopenia, unspecified;
- (XIV) Dementia in conditions classified elsewhere;
- (XV) Polyneuropathy in diseases classified elsewhere;
- (XVI) Alcoholic polyneuropathy;
- (XVII) Regional enteritis of small intestine;
- (XVIII) Postgastric surgery syndromes;
- (XIX) Other prophylactic chemo-therapy;
- (XX) Intestinal bypass or anastomosis status;
- (XXI) Acquired absence of stomach;
- (XXII) Pancreatic insufficiency; and
- (XXIII) Ideopathic progressive polyneuropathy;

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

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

**[31.]33.** Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

**[32.]34.** Nutrition therapy.

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

- (I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;
- (II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;
- (III) Nutrition therapy is necessary to sustain life or health;
- (IV) Nutrition therapy is prescribed by a provider; and
- (V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

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

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

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

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

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

**[34.]36.** Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be

initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

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

- A. Acute traumatic injury, and post-surgical sequela;
- B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;
- C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or
- D. Physical or physiological abnormality when one (1) of the following criteria is met:

- (I) Anteroposterior Discrepancies—
  - (a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);
  - (b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or
  - (c) These values represent two (2) or more standard deviation from published norms;

- (II) Vertical Discrepancies—
  - (a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;
  - (b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;
  - (c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or
  - (d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

- (III) Transverse Discrepancies—
  - (a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or
  - (b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

- (IV) Asymmetries—
  - (a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;
  - (V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);
  - (VI) Speech impairment; or
  - (VII) Obstructive sleep apnea or airway dysfunction;

**[36.]38.** Orthotics.

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

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

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

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

- I. Member is covered for AFO; and
- II. Additional knee stability is required; and
- (c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

- I. The member could not be fitted with a prefabricated AFO;
- II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;
- III. Knee, ankle, or foot must be controlled in more than one (1) plane;

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

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

(II) AFO and KAFO Not Used During Ambulation.

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

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

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

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

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

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

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

VII. Member has plantar fasciitis.

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

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

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

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

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

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

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

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

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

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

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

(I) Orthopedic footwear;

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

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

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

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

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

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

(a) Acute plantar fasciitis;

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

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

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

(g) Medial osteoarthritis of the knee;

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

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

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

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

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

(a) Hallux valgus deformities;

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

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

(d) Structural deformities such as tarsal coalitions; or

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

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

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

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

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

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

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

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

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

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

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

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

J. Orthopedic Footwear for Diabetic Members.

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

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

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

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

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

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

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

one (1) year:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**[37.]39. Preventive services.**

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

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

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

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

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

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

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

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. **[Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older] Online weight management program offered through the plan's exclusive provider arrangement;**

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

**[39.]41. Pulmonary rehabilitation.** Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for

pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

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

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

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

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ( $VO_2$ max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

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

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

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

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

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

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

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

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

B. Occupational therapy must meet the following criteria:

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

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

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

C. Speech therapy.

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

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

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

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one



supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

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

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

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

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

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.

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

(III) Meals—not covered.

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

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

[45.]47. Vision. One (1) routine exam and refraction is covered per calendar year.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RULE**

**22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 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, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling*

*governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency 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. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Deductible—per calendar year for network: per individual, seven hundred fifty dollars (\$750); family, one thousand five hundred dollars (\$1,500) and for non-network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services 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 eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, two thousand two hundred fifty dollars (\$2,250); family, four thousand five hundred dollars (\$4,500) and for non-network: per individual, four thousand five hundred dollars (\$4,500); family, nine thousand dollars (\$9,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and

non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans during the plan year or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments.

(A) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(B) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible, and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating

subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 3—Public Entity Membership**

**EMERGENCY RULE**

**22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1250 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, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency 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. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Deductible—per calendar year for network: per individual, one thousand two hundred fifty dollars (\$1,250); family, two thousand five hundred dollars (\$2,500) and for non-network: per individual, two thousand five hundred dollars (\$2,500); family, five thousand dollars (\$5,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompli-

ance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services 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 eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, three thousand seven hundred fifty dollars (\$3,750); family, seven thousand five hundred dollars (\$7,500) and for non-network: per individual, seven thousand five hundred dollars (\$7,500); family, fifteen thousand dollars (\$15,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health

Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager systems, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled, the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars (\$25); mental health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: the lesser of twenty dollars (\$20) or fifty percent (50%) of the total cost of services; urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(C) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible, and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 3—Public Entity Membership**

**EMERGENCY RESCISSION**

**22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan Limitations.** This rule established the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan.

*PURPOSE: This rule is being rescinded because the PPO 600 and PPO 1000 Plans will not be offered after December 31, 2018.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability*

of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

*AUTHORITY:* section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rescission covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RULE**

**22 CSR 10-3.061 Plan Limitations**

*PURPOSE:* This rule establishes the policy of the board of trustees in regard to the PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT:* This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting

the MCHCP trust fund from more costly expenses. This emergency 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. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-3.057 or 22 CSR 10-3.090.

(A) Abortion—unless the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(B) Acts of war including—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(C) Alternative therapies—that are outside conventional medicine including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

(D) Assistive listening device.

(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.

(F) Athletic enhancement services and sports performance training.

(G) Autopsy.

(H) Birthing center.

(I) Blood donor expenses.

(J) Blood pressure cuffs/monitors.

(K) Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

(M) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(N) Childbirth classes.

(O) Comfort and convenience items.

(P) Cosmetic procedures.

(Q) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

(R) Dental care, including oral surgery.

(S) Devices or supplies bundled as part of a service are not separately covered.

(T) Dialysis received through a non-network provider.

(U) Educational or psychological testing unless part of a treatment program for covered services.

(V) Examinations requested by a third party.

(W) Exercise equipment.

(X) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

(Y) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(Z) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(AA) Health and athletic club membership—including costs of enrollment.

(BB) Hearing aid replacement batteries.

(CC) Home births.

(DD) Infertility treatment beyond the covered services to diagnose the condition.

(EE) Infusions received through a non-network provider.

(FF) Level of care, greater than is needed for the treatment of the illness or injury.

(GG) Long-term care.

(HH) Maxillofacial surgery.

(II) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

(JJ) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(KK) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

(LL) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(MM) Nocturnal enuresis alarm.

(NN) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

(OO) Non-medically necessary services.

(PP) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(QQ) Non-reusable disposable supplies.

(RR) Online weight management programs.

(SS) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

(TT) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

(UU) Physical and recreational fitness.

(VV) Private-duty nursing.

(WW) Routine foot care without the presence of systemic disease that affects lower extremities.

(XX) Services obtained at a government facility if care is provided without charge.

(YY) Sex therapy.

(ZZ) Surrogacy—pregnancy coverage is limited to plan member.

(AAA) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

(CCC) Travel expenses.

(DDD) Vaccinations requested by third party.

(EEE) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. 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 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.080 Miscellaneous Provisions.** The Missouri Consolidated Health Care Plan is amending section (5).

*PURPOSE: This amendment revises the names of the medical plans.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity*

employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(5) The PPO [600] 750 Plan, PPO [1000] 1250 Plan, and Health Savings Account Plan benefits including pharmacy are self-funded by the plan. MCHCP has subrogation rights under section 376.433, RSMo for any amounts expended for these benefits.

*AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Amended: Filed Oct. 29, 2014, effective May 30, 2015. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is amending the purpose and section (1).

*PURPOSE: This amendment revises the names of the medical plans, copayments, preventive drugs, and out-of-pocket maximum.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the [PPO 600 Plan, PPO 1000 Plan] PPO 750 Plan, PPO 1250 Plan, Health Savings Account (HSA) Plan of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability*

*of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO [600] 750 Plan and PPO [1000] 1250 Plan Prescription Drug Coverage.

1. Network.

A. Preferred formulary generic drug copayment: [Eight dollars (\$8)] **Ten Dollars (\$10)** for up to a thirty-one- (31-) day supply; [sixteen dollars (\$16)] **twenty dollars (\$20)** for up to a sixty- (60-) day supply; and [twenty-four dollars (\$24)] **thirty dollars (\$30)** for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Preferred formulary brand drug copayment: [Thirty-five dollars (\$35)] **Forty dollars (\$40)** for up to a thirty-one- (31-) day supply; [seventy dollars (\$70)] **eighty dollars (\$80)** for up to a sixty- (60-) day supply; and [one hundred and five dollars (\$105)] **one hundred twenty dollars (\$120)** for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary.

**D. Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;**

[D.]E. Diabetic drug (as designated as such by the PBM) copayment: [f]Fifty percent (50%) of the applicable network copayment.

[E.]F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescription(s) will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2)

orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: *[Eight dollars (\$8)] Ten dollars (\$10)* for up to a thirty-one- (31-) day supply; *[sixteen dollars (\$16)] twenty dollars (\$20)* for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: *[Thirty-five dollars (\$35)] Forty dollars (\$40)* for up to a thirty-one- (31-) day supply; *[seventy dollars (\$70)] eighty dollars (\$80)* for up to a sixty- (60-) day supply; and *[eighty-seven dollars and fifty cents (\$87.50)] one hundred dollars (\$100)* for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d) Specialty drug (as designated as such by the PBM) copayment: **Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;**

*[F./G.]* Diabetic drug (as designated as such by the PBM) copayment: *[f/Fifty percent (50%) of the applicable network copayment.*

*[G./H.]* Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

*[H./I.]* The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

*[I./J.]* If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

*[J./K.]* If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum.

**L. Preferred select brand drugs, as determined by the PBM: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply;**

*[K./M.]* Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and

Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

*[(I)] Prescribed Vitamin D for all ages;*

*(a) The range for preventive Vitamin D at or below 1000 IU of Vitamin D<sub>2</sub> or D<sub>3</sub> per dose;*

*(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]*

*[(III)](I) [Influenza v]accine [and administration as] recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;*

*[(IV)](II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;*

*[(V)](III) Prescribed preferred diabetic test strips and lancets; and*

*[(VI)](IV) One (1) preferred glucometer.*

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

*[C. PPO 600 Individual—five thousand one hundred dollars (\$5,100).*

*D. PPO 600 Family—ten thousand two hundred dollars (\$10,200).*

*E. PPO 1000 Individual—two thousand one hundred dollars (\$2,100).*

*F. PPO 1000 Family—four thousand two hundred dollars (\$4,200).]*

**C. Network individual—four thousand one hundred fifty dollars (\$4,150).**

**D. Network family—eight thousand three hundred dollars (\$8,300).**

**E. Non-network—no maximum.**

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Preferred formulary generic drug: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: *[f/Fifty percent (50%) of the applicable network coinsurance after deductible has been met.*

E. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2)



orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

*[(I)] Prescribed Vitamin D for all ages.*

*(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D<sub>2</sub> or D<sub>3</sub> per dose;*

*[(II)] Zoster (shingles) vaccine and administration for members age fifty (50) years and older;*

*[(III)](I) [Influenza v] Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and*

*[(IV)](II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;*

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer.

H. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: ~~f~~Fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

29, 2019. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June*