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SALUS POPULI SUPREMA LEX ESTO

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

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

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

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

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

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

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

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

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

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

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

Title 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 2—Health Requirements for Movement of Livestock, Poultry, and Exotic Animals

EMERGENCY AMENDMENT

2 CSR 30-2.020 Movement of Livestock, Poultry, and Exotic Animals Within Missouri. The department is amending subsections (6)(A)–(D) and adding subsection (6)(E).

PURPOSE: This amendment adds the requirement of movement to be accompanied by a Certificate of Veterinary Inspection or a Breeder's Movement Certificate, changes brucellosis and tuberculosis testing requirements, and adds a provision for hunting preserves.

EMERGENCY STATEMENT: The current regulations do not require any Chronic Wasting Disease (CWD) testing to provide surveillance in our captive cervid facilities. Due to the recent outbreaks of CWD in Iowa, Minnesota, and Pennsylvania, it is essential to test cervids moving within our state for CWD to protect both the captive and free-ranging cervids; therefore, creating the emergency need for this regulation. The cervid industry will market and transport the majority (85%–90%) of the animals within the next two (2) months, thus creating the need for the emergency amendment. The surveillance prior to the hearing was conducted on hunting preserves and participants in the Voluntary CWD Program. The hunting preserve industry was not aware the testing requirement was removed from the MDC Wildlife Code in 2009, thus currently the CWD surveillance is conducted from samples submitted by participants in the Voluntary CWD Program. This does not provide adequate surveillance to identify a CWD outbreak in the initial phase of the disease outbreak. Missouri has had sixteen (16) cervids confirmed for CWD and five (5) cases have been located in free-ranging deer, which makes surveillance necessary because it provides early detection and enables us to control and eradicate diseases. Within the past year, Missouri has had traces from the Iowa and Minnesota CWD outbreak and currently has two (2) producers waiting for permits to allow importation for eight (8) cervids originating in Pennsylvania pending the completion of their epidemiological investigation. Missouri imports several cervids from Iowa, Minnesota, and Pennsylvania, and even though we evaluate these imports to ensure the risk is low, the recent outbreaks provides further evidence of the urgency of increased surveillance of Missouri producers. The delay of the implementation of the rules for six (6) months would result in a delay in the documentation of movement within hunting preserves and surveillance in cervid producers within Missouri for at least one (1) year and probably two (2) years. The proposed regulations require hunting preserves to maintain an inventory of animals (identification, individual purchased from, and date of purchase) moved into the premises and name and address of individuals harvesting the animals. MDA has met with the cervid industry throughout the year to negotiate the wording and requirements of the proposed regulations to ensure the rules would provide the necessary surveillance and movement information, yet would not be so burdensome on the industry to hinder commerce. Due to the timing and proximity to the MDC emergency amendment requesting a moratorium on the issuance of permits to new hunting facilities, the cervid industry objected to the rules proposed by MDA. Since the hearing, MDA has engaged in negotiations with the cervid industry to ensure the emergency amendment is not extremely burdensome or costly to their industry. Missouri has over three hundred (300) captive cervid facilities and approximately one hundred seventy-five (175) facilities participate in the Voluntary CWD Program; therefore, the industry feels strongly about the increased surveillance requirement for producers moving cervids within Missouri. In order for producers to be in compliance by the next marketing opportunity, this amendment must become effective immediately. The producers will need to have cervids tested and be compliant with program standards for one (1) year to enable them to move cervids within Missouri. In addition, the current tuberculosis and brucellosis requirements must be amended to strike an effective balance between protecting against such diseases and enabling cervid producers to affordably move cervids within Missouri. The current regulations cost producers approximately five hundred dollars ($500), in addition to the increased stress and death loss to the animals during the testing process. Missouri has approximately one hundred (100) producers in disease certification programs that can currently move their animals without additional testing. There are approximately two hundred (200) producers that are required to test their animals under the current regulations; however, this emergency amendment would reduce their cost of commerce by approximately two hundred fifty dollars ($250), and allow them to market their animals during this current marketing opportunity. Without this emergency amendment, the two hundred (200) cervid producers unable to move their animals will not receive their annual anticipated income, but will still have their feed and hay expenses for this year and the upcoming year to pay. The cervid producers currently not participating in the Voluntary CWD Program would not have time to achieve a Status Level 1 if the rules are not implemented to be effective January 1. They would only have three to six (3–6) months of surveillance by next fall, thus not meet the requirements for movement until the fall of 2014. The industry has a short window of marketing ability in the fall, typically from October 1 through December 1, and without the emergency amendment will be financially devastated due to the inability to move and market animals within Missouri, thus not enabling them to recover their fixed expenses

incurred throughout the year. It is imperative we move forward with the emergency amendment to enable cervid producers to market their animals in the current window of opportunity during the next two (2) months and enable them to obtain a status in the Voluntary CWD Program to allow them to market their animals in next year's market. The industry is supportive of the regulations and is anxiously awaiting the approval to file as an emergency amendment; without this emergency amendment our cervid industry will fail financially. This emergency amendment is necessary to preserve a compelling governmental interest requiring an early effective date. 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 of Agriculture believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2012, becomes effective November 8, 2012, and expires May 6, 2013.*

(6) Captive Cervids.

(A) Captive cervids including but not limited to elk, elk-hybrids, red deer, roe deer, white-tailed deer, mule deer, sika deer, moose, reindeer, mutjac, and fallow deer exchanged, bartered, gifted, leased, or sold in Missouri must be individually identified by official eartag as defined in Title 9, *Code of Federal Regulations*, Part 71, published by the United States Superintendent of Documents, 732 N Capital Street NW, Washington, DC 20402-0001, phone: toll free (866) 512-1800, DC area (202) 512-1800, website: http://bookstore.gpo.gov, legible tattoo, or any other means of permanent identification approved by the state veterinarian **and be individually listed on a Certificate of Veterinary Inspection or a Breeder's Movement Certificate**. This rule does not incorporate any subsequent amendments or additions.

1. Breeder's Movement Certificate. A form provided by the Missouri Department of Agriculture (MDA) which documents the movement of cervids within Missouri. The form may be completed by the breeder and must list the official identification, age, gender, species of the cervids moving within Missouri, and a complete address of the farm of origin and destination. The form will also list any required testing and Chronic Wasting Disease (CWD) status of the herd of origin. The original will accompany the shipment and a copy will be submitted to the MDA within thirty (30) days of movement.

(B) Brucellosis Requirements.

1. All sexually intact animals six (6) months of age and older, not under quarantine and not affected with brucellosis must *[test negative for brucellosis within ninety (90) days prior to movement]* **have a negative brucellosis test within one (1) year prior to movement (negative test date must be listed on the Certificate of Veterinary Inspection or on the Breeder's Movement Certificate)** except—

[A. Brucellosis-free herd—captive cervids originating from certified brucellosis-free herd may move on herd status without additional testing provided the certified herd number and current test date is listed on the Certificate of Veterinary Inspection; and

B. Brucellosis-monitored herd—all sexually intact animals six (6) months of age and older must test negative for brucellosis within ninety (90) days prior to movement.]

A. Captive cervids originating from certified brucellosis-free herds may move on the current herd number and test date;

B. Captive cervids moving directly to a slaughter facility; and

C. Movement to a licensed livestock market or premises of licensed dealer provided the cervids are tested within five (5) days and are quarantined and isolated pending test results. All records must be kept for five (5) years and available for inspection by a representative of the MDA upon request.

(C) Tuberculosis Requirements.

1. Captive cervids, *[less than]* six (6) months of age **and older**, not known to be affected or exposed to tuberculosis and not in a status herd must have one (1) tuberculosis test, *[not less than ninety (90) days]* **within one (1) year** prior to movement, using the single cervical method*[. The negative test date must be listed on the Certificate of Veterinary Inspection. Captive cervids must have been isolated from other captive cervids during the testing period.]* **or program-approved test (negative test date must be listed on the Certificate of Veterinary Inspection or listed on a Breeder's Movement Certificate), except—**

A. Captive cervids originating from accredited tuberculosis-free herds may move on the current herd number and test date;

B. Captive cervids moving directly to a slaughter facility; and

C. Movement to a licensed livestock market or premises of licensed dealer provided the cervids are tested within five (5) days and are quarantined and isolated pending test results. All records must be kept for five (5) years and available for inspection by a representative of the MDA upon request.

[2. Captive cervids six (6) months of age and over not known to be affected with or exposed to tuberculosis and not in a status herd must have two (2) tuberculosis tests, not less than ninety (90) days apart, using the single cervical method. The second test must be within ninety (90) days prior to movement. Both negative tests dates must be listed on the Certificate of Veterinary Inspection. Captive cervids must have been isolated from other captive cervids during the testing period.

3. Movement from status herds.

A. Accredited herd—captive cervids originating from accredited tuberculosis-free herds may move on the current herd number and test date.

B. Qualified herd—captive cervids originating from a qualified herd must have one (1) negative tuberculosis test, using the single cervical method, within ninety (90) days prior to date of movement.

C. Monitored herd—captive cervids originating from a monitored herd must have one (1) negative tuberculosis test, using the single cervical method, within ninety (90) days prior to the date of movement.

D. Captive cervids less than twelve (12) months of age that originate from and were born in a qualified or monitored herd may be moved without further tuberculosis testing, provided that they have not been exposed to captive cervids from a lower status herd.]

(D) Chronic Wasting Disease.

1. All cervids over one (1) year of age must be enrolled in a *[Chronic Wasting Disease (]*CWD*[)]* program sponsored by the Department of Agriculture. Original anniversary date must be listed on the Certificate of Veterinary Inspection **or Breeder's Movement Certificate**. **After January 1, 2013, all cervids must have a CWD Status Level of 1 to move within Missouri**.

2. All suspected or confirmed cases of CWD must be reported to the state veterinarian.

3. All captive cervids from infected or source herds will be quarantined.

(E) Hunting Preserves.

1. Must be permitted with the Missouri Department of Conservation (MDC) and comply with all regulations of the Wildlife Code.

2. Must maintain records of all purchased and harvested cervids.

A. Documentation must be maintained for five (5) years and provided for inspection to MDA and MDC authorities upon request. Records required include the name and address of the individual harvesting the animal, identification and origin (owner and address) of the harvested animal, and Certificate of Veterinary Inspection or Breeder's Movement Certificate required

for movement.

B. Any cervids entering the hunting preserve must be officially identified and listed on a Certificate of Veterinary Inspection or Breeder's Movement Certificate.

*AUTHORITY: section 267.647, RSMo 2000. Original rule filed April 18, 1975, effective April 28, 1975. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 29, 2012, effective Nov. 8, 2012, expires May 6, 2013. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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 proposes to amend section (1).

PURPOSE: This amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2013.

*EMERGENCY STATEMENT: The director of revenue is mandated to establish not later than October 22, an 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 2013 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, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

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

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

*AUTHORITY: section 32.065, RSMo 2000. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 22, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is deleting sections (12), (30), and (46); amending sections (6), (13), (18), (21), (22), (26), (34), (43), (45), (52), (60), (63), (66), and (68); and renumbering as necessary.

PURPOSE: This amendment 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, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(6) *[Allowable]* **Allowed** amount. Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed (see balance billing, section (8)).

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

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

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

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

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

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

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

*[(19)]***(18)** Disease management. A program offered to members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

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

(A) Doctor of medicine;

(B) Doctor of osteopathy;

(C) Podiatrist;

(D) Optometrist;

(E) Chiropractor;

(F) Psychologist;

(G) Doctor of dental medicine, including dental surgery;

(H) Doctor of dentistry; or

(I) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(21)]***(20)** Effective date. The date on which coverage takes effect *[as described in 22 CSR 10-2.020(4)]*.

*[(22)]***(21)** Eligibility date. The first day a member is qualified to enroll for coverage *[as described in 22 CSR 10-2.020(2)]*.

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

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

(A) Placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) With respect to a pregnant woman who is having contractions—

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

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

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

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

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

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

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

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

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

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

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

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

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

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

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

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

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

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

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

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

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

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

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

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

*[(32)]***(30)** Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager and covered by the plan administrator.

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

*[(34)]***(32)** Health assessment (HA). A questionnaire about a member's health and lifestyle habits required for participation in the *[Lifestyle Ladder]* **wellness** program.

*[(35)]***(33)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA.

*[(36)]***(34)** High Deductible Health Plan (HDHP). 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.

*[(37)]***(35)** Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered an illness.

*[(38)]***(36)** Incident. A definite and separate occurrence of a condition.

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

*[(40)]***(38)** Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.

*[(41)]***(39)** Long-term disability subscriber. A subscriber eligible for long-term disability coverage from Missouri State Employees' Retirement System (MOSERS), Missouri Department of Transportation and Highway Patrol Employees' Retirement System (MPERS), or another retirement system whose members are grandfathered for coverage under the plan by law.

*[(42)]***(40)** MCHCPid. An individual MCHCP member identifier used for member verification and validation.

*[(43)]***(41)** myMCHCP. A secure MCHCP member website that allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, **retrieve and send secure messages, upload documents,** and access health plan websites.

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

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

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

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

*[(45)]***(43)** *[Medicare-approved]* **Medicare-allowed** amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a health care provider.

[(46) Medicare assignment. When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.]

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

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

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

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

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

*[(52)]***(49)** Participant. Shall have the same meaning as the term member defined herein (see member, section *[(47)]***(44)**).

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

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

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

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

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

*[(58)]***(55)** Primary care physician (PCP). An internist, family/general practitioner, or pediatrician.

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

*[(60)]***(57)** Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010*[(20)]***(19)**. Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

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

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

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

(E) Chiropractor;

(F) Licensed Clinical Social Worker;

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

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

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

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

*[(63)]***(60)** Retiree. *[A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020(2)(D) and is currently receiving a monthly retirement benefit from a retirement system listed in such rule.]* **Notwithstanding any provision of law to the contrary, for the purposes of these regulations a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from a state-sponsored retirement system.**

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

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

*[(66)]***(63)** Specialty medications. *[High]* **High-**cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

*[(67)]***(64)** State. Missouri.

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

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

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

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

*[(72)]***(69)** 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.

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

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

*[(75)]***(72)** 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.

*[(76)]***(73)** 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.

*[(77)]***(74)** Vendor. The current applicable third-party administrators of MCHCP benefits.

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-2.020 General Membership Provisions. This rule established the policy of the board of trustees in regard to the general membership provisions of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify 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 rescission must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-2.020 General Membership Provisions

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 rule must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) Terms and Conditions. This rule provides the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). Members are required to provide complete, true, and accurate information to MCHCP in connection with enrollment, change, or cancellation processes, whether by online, written, or verbal communication. MCHCP may rely on, but reserves the right to audit, any information provided by members and seek recovery and/or pursue legal action to the extent members have provided incomplete, false, or inaccurate information.

(2) Eligibility Requirements.

(A) Active Employee Coverage.

1. An active employee may enroll in one (1) of MCHCP's plans if s/he is an employee whose position is covered by the Missouri State Employees' Retirement System (MOSERS) or another retirement system whose members are grandfathered for coverage under the plan by law. The active employee is eligible to enroll in medical, dental, or vision coverage.

2. An active employee whose position is covered by MOSERS and is employed by the Missouri Department of Conservation may only participate in an MCHCP dental or vision plan.

3. An active employee may participate in an MCHCP dental or vision plan if s/he is an employee whose position is covered by the Missouri Department of Transportation and Highway Patrol Employees' Retirement System (MPERS).

4. If an active employee has elected coverage as a dependent of another MCHCP subscriber as allowed by these rules, and the subscriber dies before coverage as a dependent goes into effect, the active employee may elect coverage as a subscriber within thirty-one (31) days of the date of death.

5. An active employee cannot be covered as an employee and as a dependent.

6. A subscriber may enroll eligible dependents as long as the employee is also enrolled subject to the provisions herein.

(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 dependents, provided the employee and any dependents 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 dependents covered) is required.

2. An employee may participate 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 participate 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 currently 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. A retiree who returns to state employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

6. If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

(C) Survivor Coverage.

1. At the time of the subscriber's death, a survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits from MOSERS or PSRS and his/her dependents may elect or continue coverage if the survivor and his/her dependents had coverage—

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 subscriber's death. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. A survivor of a retiree or terminated vested subscriber may continue coverage if the survivor had MCHCP coverage as a dependent at the time of the subscriber's death.

3. If a survivor adds a new spouse to his/her coverage and the survivor subsequently dies, the new spouse is no longer eligible for coverage.

4. If a survivor or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

(D) Terminated Vested Coverage.

1. An employee may participate in an MCHCP plan when his/her employment with the state terminates if s/he is vested and is eligible for a future benefit from MOSERS or PSRS as a state employee when s/he reaches retirement age. The employee must elect to continue coverage within thirty-one (31) days of the last day of the month in which his/her employment is terminated. The employee and his/her dependents may elect or continue coverage if the terminated vested employee and his/her dependents had coverage—

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 termination of state employment. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. If a terminated vested employee does not elect coverage within thirty-one (31) days of their eligibility date, or if s/he cancels or loses his/her coverage or dependent coverage, the terminated vested employee and his/her dependents cannot enroll at a later date.

3. The terminated vested employee may temporarily continue coverage under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA).

4. Upon receiving an annuity or retirement benefit from MOSERS or PSRS, an enrolled terminated vested employee and his/her dependents will automatically continue coverage as a retiree.

5. Upon receiving a retirement benefit from Missouri Department of Transportation and Highway Patrol Employees' Retirement System (MPERS), an enrolled terminated vested employee shall notify MCHCP of his/her retirement status to continue coverage as a retiree.

(E) Long-Term Disability Coverage.

1. An employee is eligible for long-term disability coverage if the employee is eligible for long-term disability benefits from MOSERS or PSRS and the employee and his/her dependents may elect or continue coverage if the employee with long-term disability coverage and his/her dependents had coverage—

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 becoming eligible for long-term disability benefits. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. If an enrolled, vested, long-term disability subscriber becomes ineligible for disability benefits, the long-term disability subscriber and his/her dependents will have continuous coverage as a terminated vested subscriber. If an enrolled long-term disability subscriber is not vested, and becomes ineligible for disability benefits, coverage is terminated and the subscriber and his/her dependents are offered COBRA benefits. If an enrolled long-term disability subscriber becomes ineligible for disability benefits, and returns to work, the subscriber is considered a new employee and must enroll through Statewide Employee Benefit Enrollment System (SEBES).

3. If the employee's spouse is an active state employee or retiree, s/he may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change, as long as coverage is continuous. If the employee returns to work, the employee and

his/her state employee spouse must be covered individually.

4. Upon receiving an annuity or retirement benefit from MOSERS or PSRS, an enrolled long-term disability employee and his/her dependents will automatically continue coverage as a retiree.

5. Upon receiving a retirement benefit from MPERS, an enrolled long-term disability employee must notify MCHCP of his/her retirement status to continue coverage as a retiree.

(F) Elected State Official Coverage.

1. Members of the General Assembly, state officials holding a statewide office, or employees of members of the General Assembly or state officials and his/her dependents may continue coverage in an MCHCP plan if employment terminates because the member of the General Assembly or state official ceases to hold elected office. The elected state official or his/her employees must elect to continue coverage for him/herself and dependents within thirty-one (31) days from the last day of the month in which his/her employment is terminated. If the subscriber does not elect coverage within thirty-one (31) days, cancels, or loses his/her coverage or dependent coverage, the subscriber and his/her dependents cannot enroll at a later date.

(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 covered subscriber or covered 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 of a dependent so long as the parent continues to be covered as a dependent of the subscriber;

(IX) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(X) 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 covered 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.

(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 within thirty-one (31) days of his/her hire date. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect coverage and/or change coverage levels during the annual open enrollment period.

3. An active employee may apply for coverage for himself/herself and/or for his/her dependents 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; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses 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 dependent 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 dependent, the active employee may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

4. If an employee is currently 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 PPO 600 Plan provided through the vendor the employee is currently enrolled in, effective the first day of the next calendar year.

5. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains 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 at retirement, the employee and his/her dependents 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 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 with proof of prior medical coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may add a dependent 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; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses 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 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 a dependent. 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 is currently 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 PPO 600 plan provided through the vendor the retiree is currently enrolled in, effective the first day of the next calendar year.

6. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains 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 add a dependent 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; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses 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 dependent. 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 is currently 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 PPO 600 plan provided through the vendor the terminated vested subscriber is currently enrolled in, effective the first day of the next calendar year.

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 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 dependent 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; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses 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 dependent. 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 is currently 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 PPO 600 plan provided through the vendor the long-term disability subscriber is currently enrolled in, effective the first day of the next calendar year.

4. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains 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 dependent must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may add a dependent 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; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses 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 dependent. 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 is currently 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 PPO 600 plan provided through the vendor the survivor is currently enrolled in, effective the first day of the next calendar year.

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

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. Unless stated otherwise by these rules, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. Except for newborns, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP.

2. The effective date of coverage for a life event shall be as follows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date subject to receipt of proof of eligibility. The monthly premium is not prorated.

(II) If an active employee enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

B. Newborn.

(I) If a subscriber or employee enrolls his/her newborn or a subscriber enrolls a newborn of his/her dependent within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) If a subscriber does not elect to enroll a newborn of a dependent within thirty-one (31) days of birth, s/he cannot enroll the dependent of a dependent at a later date;

C. Adoption or placement for adoption.

(I) If a subscriber or employee enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption;

D. Legal guardianship and legal custody.

(I) If a subscriber or employee enrolls a dependent due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

E. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the subscriber or employee's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

F. Employee.

(I) If an employee enrolls due to a life event, the effective date for the employee is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

3. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

4. An employee who terminates all employment with the state (not simply moves from one (1) agency to another) and is rehired as a new state employee before the participation in MCHCP coverage terminates, and his/her eligible dependent(s) who were covered by the plan, will have continuous coverage.

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January unless s/he is eligible due to a life event.

5. An employee who terminates all employment with the state and is rehired in the following month and his/her eligible dependent(s) who were covered by the plan may choose to have continuous coverage or coverage the first of the month after his/her hire date if an enrollment form is submitted within (31) days of hire date.

A. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

B. If the employee requests coverage to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event.

6. An employee who transfers in the same month from a state agency with MCHCP benefits to another agency with MCHCP benefits, and his/her eligible dependent(s) who were covered, will have continuous coverage. The employee must inform the former agency of the transfer in lieu of a termination. The employee will be transferred through eMCHCP by the former state agency's human resource or payroll representative to the new state agency.

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event.

7. An employee who transfers state employment from the Missouri Department of Transportation (MoDOT), Missouri State Highway Patrol, or the Department of Conservation and his/her dependents to another agency with MCHCP benefits will maintain his/her dental and/or vision coverage and may enroll in medical coverage within thirty-one (31) days of transfer. If enrollment is made within thirty-one (31) days of transfer, MCHCP medical coverage is

effective with no break in coverage. Dental and vision coverage is continuous throughout the calendar year. An employee cannot enroll in dental and vision at the time of transfer if s/he was not enrolled prior to the transfer.

A. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January unless s/he is eligible due to a life event.

8. A state employee who has medical coverage under MCHCP and transfers state employment to MoDOT, Missouri State Highway Patrol, or the Department of Conservation and his/her dependents are no longer eligible for MCHCP coverage. MCHCP medical coverage is terminated the last day of the month of the employee's termination.

9. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(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 letter date, 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.

(A) Addition of Dependents. Required documentation should accompany the enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the enrollment will result in the dependent not having coverage until such proof is received, subject to the following:

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. 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;

2. Coverage is provided for a newborn of a member from the moment of birth. The member must initially 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 of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue 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; and

3. If placement papers or filed petition for adoption were used as proof of eligibility, final adoption papers must be submitted to MCHCP within one hundred eighty (180) days from the enrollment date.

(B) Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption listing subscriber as adoptive parent
Legal guardianship or legal custody of dependent(s)	Court-documented guardianship or custody papers listing member as guardian or custodian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Government-issued death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified Medical Child Support Order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, length of coverage, reason for coverage termination, and list of dependents covered
TRICARE Supplemental Coverage	Military ID Card
Medicare	Medicare Card

(C) An active employee, retiree, terminated vested subscriber, long-term disability subscriber, or survivor and all eligible dependents who qualify to receive a military ID card must submit a copy of their military ID card(s) to enroll in the TRICARE Supplement Plan.

(D) An employee and/or his/her dependents enrolling due to a loss of employer-sponsored group coverage. The employee must submit documentation of proof of loss within sixty (60) days of enrollment.

(E) A retiree, survivor, terminated vested subscriber, or long-term disability subscriber enrolling dependents due to a loss of employer-sponsored group coverage. The retiree, survivor, terminated vested subscriber, or long-term disability subscriber must submit documentation of proof of loss for his/her dependents within sixty (60) days of enrollment.

(F) The employee is required to notify MCHCP on the appropriate form of the dependent's name, birth date, eligibility date, and Social Security number.

(G) Disabled Dependent.

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

A. Evidence that the permanently disabled dependent was entitled to and receiving disability benefits prior to turning age twenty-six

(26). Evidence could be from the Social Security Administration, representation from the dependent's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's physician describing the current disability and verifying that the disability predates the dependent's twenty-sixth birthday and the disability is permanent; and

C. A benefit verification letter dated within the last twelve (12) months from the Social Security Administration (SSA) confirming the dependent is still considered disabled by SSA.

2. If a disabled child over the age of twenty-six (26) is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends.

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

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

(6) Military Leave.

(A) Military Leave for an Active Employee.

1. For absences of thirty (30) days or less, coverage continues as if the employee has not been absent.

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for coverage under the Uniformed Services Employment & Reemployment Rights Act (USERRA). The agency payroll representative must notify MCHCP of the effective date of military leave. An employee who is on military leave is eligible for continued coverage for medical, vision, and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment after leave.

3. If the employee is utilizing annual and/or compensatory balances and receiving a payroll, the dependent coverage is at the active employee monthly premium.

4. If the employee does not elect to continue USERRA coverage for his/her eligible dependent(s), coverage ends effective the last day of the month in which the leave begins.

5. The employee must submit a form within thirty-one (31) days of the employee's return to work to be reinstated for the same level of coverage with the same plan as prior to the leave. The employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work. The form and the official document must be submitted within sixty (60) days from the date of loss of coverage.

6. Coverage may be reinstated the first of the month in which the member returns to employment, the first of the month after return to employment, or the first of the month after the loss of military coverage.

(B) Military Leave for a Retired Member.

1. A retiree must terminate his/her coverage upon entry into the armed forces of any country by submitting a form and copy of his/her activation papers within thirty-one (31) days of his/her activation date.

2. Coverage will be terminated the last day of the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of his/her separation papers and form within thirty-one (31) days of the separation date.

3. Coverage will be reinstated as of the first of the month in which the employee returns from active duty, the first of the month after the employee returns, or the first of the month after the loss of military coverage.

4. If the retired member fails to reinstate coverage, s/he cannot enroll at a later date.

5. If the retiree terminates his/her coverage, dependent coverage is also terminated.

6. If a retiree does not elect to continue USERRA coverage for his/her eligible dependent(s), coverage ends effective the last day of the month in which the leave begins.

(7) Termination.

(A) Unless stated otherwise, termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make any required contribution toward the cost of coverage. If MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, the subscriber will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period;

2. Entry into the armed forces of any country;

3. With respect to active employee(s) and his/her dependents, termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule;

4. With respect to dependents, upon divorce or legal separation from the subscriber, when a child reaches age twenty-six (26), or when a dependent is no longer eligible for coverage. A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP;

5. Death of dependent. The dependent's coverage ends on the date of death. The subscriber must submit completed form and a copy of the death certificate within thirty-one (31) days of death;

6. A member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact; or

7. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP.

(B) MCHCP may rescind coverage due only to non-payment of a premium, fraud, or intentional misrepresentation. MCHCP shall provide at least thirty (30) days written notice before it rescinds coverage.

(C) Termination of coverage shall occur immediately upon discontinuance of the plan, subject to the plan termination provision specified in 22 CSR 10-2.080(1).

(D) If a member receives covered services after the termination of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the subscriber notifies MCHCP to cancel coverage.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(B) If a member receives covered services after the voluntary cancellation of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(C) A subscriber cannot cancel medical coverage on his/her spouse or step-children during a divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce. If

premiums are collected pre-tax through the Missouri State Employees' Cafeteria Plan (MoCafe), medical coverage can only be cancelled at the time of divorce.

(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; or
3. No longer eligible for coverage.

(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, form, and bill (if applicable) from MCHCP to continue coverage. If the completed form and payment (if applicable) are returned within ten (10) days of the date of the letter, coverage will continue and the employee will be set up on direct bill.

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

3. If the employee fails to pay the premium due, coverage on the employee and his/her dependents terminates.

4. If the employee's spouse is an active employee or retiree, the employee may transfer coverage under the plan in which the spouse is enrolled. 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.

5. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage in MCHCP while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. For coverage to be reinstated, the employee must submit a completed 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.

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

(B) Leave of Absence—Family and Medical Leave Act (FMLA).

1. An employee must be approved for a leave of absence under FMLA and meet the requirements and guidelines set forth by FMLA and his/her employing agency for his/her employer to continue to pay the monthly contribution toward the employee's and his/her dependents' coverage. Coverage is continuous unless the employee chooses to cancel coverage.

2. If the employee cancels coverage, coverage ends on the last day of the month in which MCHCP received a premium payment.

3. If the employee canceled coverage, the employee may reinstate coverage by submitting a completed form within thirty-one (31) days of returning to work. Coverage will be reinstated with the same plan and level of coverage as enrolled in prior to the employee going out on leave of absence.

4. If the employee continued coverage and is unable to return to work after his/her FMLA leave ends, his/her coverage will be continuous at the leave of absence rate or the employee may cancel coverage.

(C) Layoff. An employee on layoff status may continue participation in the plan by paying the required leave of absence premium for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. The employee will receive a letter, enrollment form, and bill from MCHCP. If the employee chooses to continue coverage, s/he must return the enrollment form and payment (if applicable) to MCHCP within ten (10) days of the date of the letter. If the employee continued coverage in a layoff status, and is two (2) months past due on his/her premiums, coverage on the employee and his/her dependents will be terminated at the end of the month payment was received. If the employee's spouse is an active state employee or retiree, the employee may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. If coverage terminates and the employee is recalled to service, eligibility will be as a new employee. If the employee returns to work with an agency covered by MCHCP, eligibility will be as a new employee. An employee and his/her spouse who is also a state employee must be covered individually.

(D) Workers' Compensation.

1. Coverage will automatically be extended to any subscriber who is on a leave of absence due to an illness or injury and receiving Workers' Compensation benefits. Coverage in the plan will be with the same plan and level of coverage (employee only or employee and dependents) and the member must continue to pay the premiums that were previously deducted from his/her paycheck.

2. If the subscriber cancels coverage, coverage will end on the last day of the month in which MCHCP received the cancellation. The employee may enroll within thirty-one (31) days of returning to work.

3. If the subscriber is no longer eligible for Workers' Compensation benefits and does not return to work, then the subscriber's status is changed to leave of absence and the subscriber is direct billed the leave of absence premium.

(E) Reinstatement after Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action, s/he will be allowed to reinstate his/her medical benefit within thirty-one (31) days of his/her reinstatement as described below—

1. If the employee is reinstated with back pay and chooses to continue coverage, s/he will be responsible for paying any back contributions normally made for his/her coverage;

2. If the employee is reinstated without back pay and chooses to continue coverage, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making the required contribution for his/her coverage;

3. If the employee does not continue coverage, s/he will be considered a new hire and may enroll in the plan of his/her choice; or

4. If the employee fails to reinstate his/her coverage, s/he cannot enroll in an MCHCP plan until the next open enrollment period.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

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

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, subscriber may add such eligible dependents to the subscriber's plan if MCHCP is notified within thirty-one (31) days of the marriage, birth, or adoption. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible for Medicare.

4. A surviving spouse and dependents who have coverage due to the death of a non-vested employee may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced or legally-separated spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) own expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

(B) Premium Payments.

1. Initial payment for continuation coverage must be received within forty-five (45) days of election of coverage.

2. After initial premium payment, MCHCP bills on the last working day of the month. There is a thirty-one- (31-) day grace period for payment of regularly scheduled monthly premiums.

3. Premiums for continued coverage will be one hundred two percent (102%) of the total premium for the applicable coverage level. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

(C) Required Notifications.

1. The subscriber or applicable member must notify MCHCP of a divorce, legal separation, a child turning age twenty-six (26), or Medicare entitlement within sixty (60) days of the event date.

2. The human resource/payroll office of the subscriber must notify MCHCP of an employee's death, termination, or reduction of hours of employment.

3. If a COBRA member is disabled within the first sixty (60) days of COBRA coverage and the disability continues for the rest of the initial eighteen- (18-) month period of continuing coverage, the member must notify MCHCP that s/he wants to continue coverage within sixty (60) days, starting from the latest of: 1) the date on which the SSA issues the disability determination; 2) the date on which the qualifying event occurs; or 3) the date on which the member receives the COBRA general notice. The member must also notify MCHCP within thirty-one (31) days of any final determination that the individual is no longer disabled.

(D) Election Periods.

1. When MCHCP is notified that a COBRA-qualifying event has occurred, MCHCP notifies eligible members of the right to choose continuation coverage.

2. Eligible members have sixty (60) days from the date of coverage loss or notification from MCHCP, whichever is later, to inform MCHCP that they want continuation coverage.

3. If eligible members do not choose continuation coverage within sixty (60) days of lost coverage or notification from MCHCP, coverage ends.

(E) Continuation of coverage may be cut short for any of these reasons—

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

4. The covered employee or dependent becomes entitled to Medicare after the date s/he elects COBRA coverage; or

5. The covered employee or dependent extends coverage for up to twenty-nine (29) months due to disability and there has been a final determination that the individual is no longer disabled.

(11) Missouri State Law COBRA Wrap-Around Provisions.

(A) Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) under two (2) conditions—

1. The member continues and maintains coverage under the thirty-six- (36-) month provision of COBRA; and

2. The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay the entire premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium.

(B) For a member to continue coverage under this subsection, a member must either—

1. Within sixty (60) days of legal separation or the entry of a decree of dissolution of marriage or prior to the expiration of a thirty-six- (36-) month COBRA period, the legally-separated or divorced spouse who seeks such coverage shall give MCHCP written notice of the qualifying event, including his/her mailing address; or

2. Within thirty (30) days of the death of an employee whose surviving spouse is eligible for continued coverage or prior to the expiration of a thirty-six- (36-) month COBRA period, the human resource/payroll representative or the surviving spouse shall give MCHCP written notice of the death and the mailing address of the surviving spouse.

(C) Within fourteen (14) days of receipt of the notice, MCHCP shall notify the legally-separated, divorced, or surviving spouse that coverage may be continued. The notice shall include:

1. A form for election to continue the coverage;

2. The amount of premiums to be charged and the method and place of payment; and

3. Instructions for returning the elections form by mail within sixty (60) days after MCHCP mails the notice.

(D) Continuation of coverage terminates on the last day of the month prior to the month the subscriber turns age sixty-five (65). The right to continuation coverage shall also terminate upon the earliest of any of the following:

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The date on which the legally-separated, divorced, or surviving spouse becomes insured under any other group health plan;

4. The date on which the legally-separated, divorced, or surviving spouse remarries and becomes insured under another group health plan; or

5. The date on which the legally-separated, divorced, or surviving spouse reaches age sixty-five (65).

(12) Medicare.

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

(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.

(C) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary

with appropriate copayments or coinsurance when the member is within the donut hole.

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

(14) Communications to Members.

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

(B) A member must notify MCHCP of a change in his/her mailing or email address as soon as possible, but no later than thirty-one (31) days after the change.

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

(D) Failure to update a mailing or email address may result in undeliverable mail/email of important informational material, delayed or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

(15) Deadlines. Unless specifically stated otherwise, MCHCP computes deadlines by counting day one as the first day after the qualifying event. If the last day falls on a weekend or state holiday, MCHCP may receive required information on the first working day after the weekend or state holiday.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed rescission and 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 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan Medical Plans.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

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

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

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

A. Ambulance services for non-emergent use**,** whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism **at initial service. Annual dollar limit may be exceeded with prior authorization**;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

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

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

H. Cochlear implant device;

I. Chelation therapy;

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

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

L. Genetic testing or counseling;

M. Home health care *[and palliative services]*;

N. Hospice care **and palliative services**;

O. Hospital inpatient services except for observation stays;

P. 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;

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

*[Q.]***R.** Nutritional counseling after three (3) sessions annually;

S. Orthognathic surgery;

*[R.]***T.** Orthotics over one thousand dollars ($1,000);

*[S.]***U.** Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

*[T.]***V.** Procedures with codes ending in "T";

*[U.]***W.** Prostheses over one thousand dollars ($1,000);

*[V.]***X.** Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

*[W.]***Y.** Skilled nursing facility;

*[X.]***Z.** Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

*[Y.]***AA.** Transplants**,** including requests related to covered travel and lodging.

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

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

B. Specialty medications;

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. *[The cost of the medication exceeds]* **Medications with costs exceeding** nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications*[.]***; and**

G. Shingles vaccines prescribed by a physician.

3. Prior authorization time frames.

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

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

(B) Concurrent Review—The claims administrator will monitor the medical necessity of *[the]* **an** inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision; and

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

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

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

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

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

(C) *[During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.]* If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(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.

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

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

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

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

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

(C) *[During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital.]* If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(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.

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (3), and (6)–(8); adding sections (6), (7), (9), and (10); and renumbering as necessary.

PURPOSE: This amendment establishes the policy of the board of trustees in regard to the High Deductible Health Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred **fifty** dollars *[($1,200)]* **($1,250)**; family each calendar year, two thousand *[four]* **five** hundred dollars *[($2,400)]* **($2,500)**. Non-network: per individual each calendar year, two thousand *[four]* **five** hundred dollars *[($2,400)]* **($2,500)**; family each calendar year, *[four]* **five** thousand *[eight hundred]* dollars *[($4,800)]* **($5,000)**.

(B) The family deductible applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered **family** member.

(C) *[During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and out-of-pocket maximum. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.]* If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(B) 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 *[claim payment]* **the plan** begins **to pay one hundred percent (100%) of all covered charges** for any covered **family** member.

(C) Network out-of-pocket maximum for individual—two thousand *[four]* **five** hundred dollars *[($2,400)]* **($2,500)**.

(D) Network out-of-pocket maximum for family—*[four]* **five** thousand *[eight hundred]* dollars *[($4,800)]* **($5,000)**.

(E) Non-network out-of-pocket maximum for individual—*[four]* **five** thousand *[eight hundred]* dollars *[($4,800)]* **($5,000)**.

(F) Non-network out-of-pocket maximum for family—*[nine]* **ten** thousand *[six hundred]* dollars *[($9,600)]* **($10,000)**.

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

(6) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.

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

*[(6)]***(8)** A *[member]* **subscriber** does not qualify for the High Deductible Health Plan (HDHP) if s/he **is claimed as a dependent on another person's tax return or, except for the plans listed in section (11) of this regulation,** is covered under or enrolled in any *[of]* **other health plan that is not a high deductible health plan, including, but not limited to,** the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

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

(D) Health reimbursement account (HRA); or

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

(9) A retiree becoming eligible for Medicare in the upcoming plan year may not enroll in the HDHP during open enrollment.

(10) If a subscriber is enrolled in the HDHP and his/her status changes to Medicare primary during the plan year, the subscriber must choose another plan within thirty-one (31) days of notice from MCHCP or if no plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan. A new plan deductible and out-of-pocket maximum will apply.

*[(7)]***(11)** A *[member]* **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.

*[(8)]***(12)** Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the employee must open a**n** HSA with the bank designated by MCHCP.

(B) *[MCHCP will make a twenty-five dollar ($25) monthly contribution to the employee's HSA account to total three hundred dollars ($300) annually. If a family is enrolled, MCHCP will make a fifty dollar ($50) contribution to the employee's HSA account to total six hundred dollars ($600) annually.]* **The MCHCP contributions will be deposited into the subscriber's HSA bi-annually as follows:**

Deposit	Subscriber Only	All other coverage levels
January 4, 2013	$150.00	$300.00
July 5, 2013	$150.00	$300.00

(C) 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 bi-annual contributions, will receive a prorated bi-annual contribution.

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

(E) 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 for a future month(s), MCHCP will not request a re-payment of the contribution(s).

*[(C)]***(F)** If both a husband and wife are state employees covered by MCHCP and they both enroll in a**n** HDHP with HSA, 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 HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a three hundred dollar ($300) contribution to each spouse to total six hundred dollars ($600).

[(9) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.]

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

*AUTHORITY: section 103.059, RSMo 2000, **and section 103.080.3., RSMo Supp. 2012**. 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. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 (2) and (4), adding sections (2) and (3), and renumbering as necessary.

PURPOSE: This amendment establishes the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(2) Transition of Care. A transition of care option is available for members living in the northeast region (which includes the following counties: Adair, Clark, Knox, Linn, Lewis, Macon, Marion, Putnam, Ralls, Schuyler, Scotland, Shelby, and Sullivan) currently using the First Health Network who will be transitioned to the UnitedHealthcare Choice Plus network effective January 1, 2013. A subscriber and his/her dependents using a health care provider who is not part of the UnitedHealthcare Choice Plus network may apply for a ninety- (90-) day transition of care to receive network benefits with his/her current provider for a period of time after January 1, 2013. A subscriber and his/her dependents may apply for additional days beyond the ninety (90) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The request for consideration must be submitted to UMR between October 1, 2012, and January 31, 2013, to be eligible for transition of care benefits. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. If a member is being treated for a condition below by a provider who is not a member of the UnitedHealthcare Choice Plus network, s/he must complete the transition of care form or call UMR directly. Eligible transition of care benefits include:

(A) Upcoming surgery or prospective transplant;

(B) Women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical cancer trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery and follow-up per criteria covered under the plan;

(M) Being treated as an inpatient at the hospital at the time of the network change;

(N) Any previous treatment for behavioral health; or

(O) Within three (3) months after an acute injury or surgery.

(3) Disease Management.

(A) A non-Medicare subscriber and his/her eligible non-Medicare dependents may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;

2. Diabetes (includes children);

3. Asthma (includes children);

4. Congestive heart failure;

5. Chronic obstructive pulmonary disease;

6. Hypertension; or

7. Depression with one (1) other disease management condition.

(B) A member identified as eligible for disease management through medical and prescription drug claims will receive an invitation to participate.

*[(2)]***(4)** Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes covered services:

1. Prescribed by an appropriate health care provider for the therapeutic treatment of injury or sickness;

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

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

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

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

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

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

(D) Services in a *[Country Outside of]* **Country Other than** the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Medical plan benefits, limitations, and exclusions **dated October 30, 2012,** effective January 1, *[2012]* **2013**, are incorporated by reference into this rule and are available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, or online at www.mchcp.org. This rule does not include any later amendments or additions.

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

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically-significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially-designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when *[medically necessary and]* other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered *[when medically necessary and]* only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of **direct** observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty**-one** thousand **two hundred sixty-three** dollar *[($40,000)]* **($41,263)** annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit *[are]* **continue to be** medically necessary;

4. Bariatric surgery. *[Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;]* **When specific criteria for bariatric surgery have been met, any of the following open or laparoscopic bariatric surgery procedures are covered when performed at a Centers of Excellence Facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services:**

A. Roux-en-Y gastric bypass;

B. Sleeve gastrectomy;

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

D. Adjustable silicone gastric banding. 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 are covered;

E. Surgical reversal of bariatric surgery is covered when complications of the original surgery (such as stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink or cause vomiting of prescribed meals; or

F. Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss is covered when specific criteria are met. Inadequate weight loss due to individual noncompliance with post-operative nutrition and exercise recommendations is not a medically necessary indication for revision or conversion surgery and is not covered;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration-(FDA-)*[-]* approved birth control devices and injections are covered when administered in a physician's office;

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

*[6.]***7.** Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable *[and medically-necessary]* services needed to administer the drug or use the device under evaluation in the clinical trial;

*[7.]***8.** Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) *[as medically necessary]* when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve- (12-) week period per incident **without prior authorization**. *[The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;]* **Any**

visits after the first thirty-six (36) within a twelve- (12-) week period per incident may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary;

*[8.]***9.** Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

*[9.]***10.** Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. *[The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;]* **Any visits after the first twenty-six (26) may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary;**

*[10.]***11.** Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is 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.

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;

*[11.]***12.** Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. **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.** The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

*[12.]***13.** Durable medical equipment (DME)/medically-necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or *[sickness (illness)]* **illness**. DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

*[13.]***14.** Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If **a member is** admitted to hospital, **s/he** may be required to transfer to network facility for maximum benefit;

*[14.]***15.** Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

*[15.]***16.** Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not *[medically necessary]* **covered** in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

*[16.]***17.** Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered *[as medically necessary]* for an individual recommended for covered heritable genetic testing;

*[17.]***18.** Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

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

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

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

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

*[19.]***20.** 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);

*[20.]***21.** Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. 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.

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

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

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

D. Bone *[Anchored]* **Anchoring** Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

*[21.]***22.** Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

*[22.]***23.** Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (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 (vocational) nurse, licensed therapist, or a registered dietitian;

*[23.]***24.** 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 *[which is]* 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;

*[24.]***25.** Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. 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;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) 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;

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

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

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

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

D. 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:

(I) 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;

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

(III) 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; and

(IV) The attending physician must be a psychiatrist. If the admitting physician 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 physician 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 not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. 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;

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

G. 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:

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

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

(III) A state-licensed psychologist;

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

(V) Licensed professional counselor;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See birth control devices and injections 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 or 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 chemotherapy;

(XX) Intestinal bypass or anastamosis status; and

(XXI) Acquired absence of stomach;

*[25.]***27.** 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;

*[26.]***28.** Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal 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. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

*[27.]***29.** Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program**.** *[when]* **Counseling must be** ordered by a physician or physician extender and provided by a licensed healthcare professional (e.g., a registered dietitian)*[,]* **for** up to three (3) sessions annually with a registered dietitian*[, with physician order]* **without prior authorization**. *[The maximum]* **Any sessions after the three (3)** may be *[exceeded for an additional three (3) sessions,]* **covered** upon prior authorization by the medical plan, if services *[beyond the maximum limit are]* **continue to be** medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program *[because they are not considered to be medically necessary]*. Conditions for which nutritional evaluation and counseling are not *[considered to be medically necessary include,]* **covered include,** but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

*[28.]***30.** Nutritional therapy. Nutritional therapy is covered when it is**—**

A. *[t]***T**he sole source of nutrition or a significant percentage of the daily caloric intake; *[is]*

B. *[u]***U**sed in the treatment of, or in association with, a demonstrable disease, condition, or disorder; *[is]*

C. *[p]***P**rescribed by a physician; *[is]*

D. *[n]***N**ecessary to sustain life or health; and

E. *[r]***R**equires ongoing evaluation and management by a licensed healthcare provider;

*[29.]***31.** Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan *[being]* provided*[, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable]*;

32. Orthognathic (jaw includes temporomandibular joint and prognathism) surgery is covered for the following specific conditions and when the conditions meet coverage criteria:

A. Acute traumatic injury and post-surgical sequela;

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

C. Obstructive sleep apnea;

D. Cleft lip/palate (for cleft lip/palate related jaw surgery); and

E. Congenital anomalies. Examples of congenital anomalies include: midface hypoplasia, Pierre Robin Syndrome, Hemifacial Microsomia, and Treacher Collins Syndrome;

*[30.]***33.** Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets—covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

*[31.]***34.** Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident**.** *[if showing significant improvement. The maximum may be exceeded,]* **Any visits after the first sixty (60) may be covered** upon prior authorization by the medical plan, if services *[beyond the maximum limit are]* **continue to be** medically necessary;

*[32.]***35.** Preventive services.

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

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

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

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

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. **Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors.** For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal *[S]***s**creening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza)—The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out of network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a *[medically-necessary]* **covered** preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a *[medically-necessary]* **covered** preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a *[medically-necessary]* **covered** alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

*[33.]***36.** Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related;

*[34.]***37.** Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve- (12-) week period per incident. *[The maximum may be exceeded]* **Any visits after the first thirty-six (36) within a twelve- (12-) week period per incident may be covered**, upon prior authorization by the medical plan, if services *[beyond the maximum limit are]* **continue to be** medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative 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) and/or work;

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

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

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

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

*[35.]***38.** Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

*[36.]***39.** Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation. Direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

*[37.]***40.** Transplants. When neither experimental nor investigational and medically necessary: *[bone marrow]* **stem cell**, kidney, liver, heart, lung, pancreas, *[intestinal]* **small bowel**, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

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

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. 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 not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

[(I) Allogenic bone marrow—one hundred forty three thousand dollars ($143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars ($121,000);

(III) Heart—one hundred twenty-eight thousand dollars ($128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars ($133,000);

(V) Lung—one hundred fifty-one thousand dollars ($151,000);

(VI) Kidney—Fifty-four thousand dollars ($54,000);

(VII) Kidney and pancreas—ninety-seven thousand dollars ($97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars ($153,000);]

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

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

*[39.]***42.** Vision. **One (1)** *[R]*routine exam (including refractions)*[. One (1)]* per covered person per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations. The Missouri Consolidated Health Care Plan is deleting sections (11), (17), (38), (43), and (47); amending sections (34),

(40), and (42); adding sections (5), (31), and (40); and renumbering as necessary.

PURPOSE: This amendment establishes the policy of the board of trustees in regard to the PPO 300 Plan, PPO 600 Plan, and HDHP Limitations of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(5) Assistive listening device.

*[(5)]***(6)** Assistant surgeon services—not covered unless determined to meet the clinical eligibility for coverage under the plan.

*[(6)]***(7)** Athletic trainer services—services by a licensed athletic trainer not covered.

*[(7)]***(8)** Autopsy.

*[(8)]***(9)** Birthing center.

*[(9)]***(10)** Blood donor expenses—not covered.

*[(10)]***(11)** Blood pressure cuffs/monitors—not covered.

[(11) Blood storage—not covered, including whole blood, blood plasma, and blood products.]

[(17) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.]

*[(18)]***(17)** Educational or psychological testing—not covered unless part of a treatment program for covered services.

*[(19)]***(18)** Examinations requested by a third party.

*[(20)]***(19)** Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

*[(21)]***(20)** Exercise equipment.

*[(22)]***(21)** Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered.

*[(23)]***(22)** Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(24)]***(23)** Services obtained at a government facility—not covered if care is provided without charge.

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

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

*[(27)]***(26)** Home births.

*[(28)]***(27)** Immunizations requested by third party or for travel.

*[(29)]***(28)** Infertility treatment. Services are covered to diagnose the condition.

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

*[(31)]***(30)** Long-term care.

(31) Maxillofacial surgery.

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

[(38) Orthognathic surgery.]

*[(39)]***(38)** Orthoptics.

*[(40)]***(39)** Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. 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. 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. *[Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment, or any late payment charge.]* **No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, filling out paperwork, or late payments.**

(40) 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.

(42) *[Private]* **Private-**duty nursing.

[(43) Prognathic and maxillofacial surgery.]

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

*[(45)]***(44)** Sex therapy.

*[(46)]***(45)** Surrogacy—pregnancy coverage is limited to plan member.

[(47) Temporomandibular Joint Syndrome (TMJ). Services are covered to diagnose the condition.]

*[(48)]***(46)** Travel expenses—not covered except for transplants in a transplant network facility.

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

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2011] **2012**. 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. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-2.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending sections (1) and (4).

PURPOSE: This amendment establishes the policy of the board of trustees in regard to the coordination of benefits (COB) in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) If a member is also covered under any other plan (as defined here) and is entitled to benefits or other services for which benefits are **also** payable under Missouri Consolidated Health Care Plan (MCHCP), the benefits under MCHCP will be adjusted as shown in this rule.

(4) Effect on the Benefits of MCHCP. This section applies, which in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

(A) In *[that]* **the** event **that MCHCP is a secondary plan as to one (1) or more other plans**, the benefits of MCHCP**'s PPO plans and High Deductible Health Plan** may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision **using the following criteria**. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

1. In the case where Medicare is primary for physician and outpatient facility claims, Medicare's allowed amount is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

2. In the case where Medicare is primary for inpatient facility claims, the amount the facility billed is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision. Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicaid paid amount. Effective April 1, 2013, Medicare's allowed amount will be used as MCHCP's allowed amount for inpatient facility claims to determine what MCHCP would have paid in absence of this COB provision and the Medicare paid amount will no longer be combined with the provider's Medicare contractual write off.

3. In the case where another plan is primary, the lower allowed amount of either the primary plan or MCHCP is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

(B) In the event that MCHCP is a secondary plan as to one (1) or more plans, the benefits of MCHCP's Medicare Supplement Plan may be reduced so as not to exceed the amount due to the provider after the benefits of the other plan have been applied. MCHCP will compare what it would have paid in absence of this COB provision to the remainder due after the benefits of the other plan were applied and pay up to what it would have paid but not more than is due the provider.

*AUTHORITY: section 103.059, RSMo 2000, and section 103.089, RSMo Supp. [2011] **2012**. 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. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (4) and (6).

PURPOSE: This amendment establishes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(4) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. *[External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical benefits administered by Coventry Health Care in accordance with state law and regulations promulgated by DIFP.]* The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR**, Coventry Health Care,** and Express Scripts**,** Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; **or**

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage*[; or]***.**

[C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.]

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor *[who will have]* **by** someone *[review the appeal]* who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor *[who will have]* **by** someone *[review the appeal]* who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor *[who will have]* **by** someone *[review the appeal]* who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First **and second** level **pre-service and concurrent claim** appeals must be submitted in writing to—

[UMR Claims Appeal Unit] **UMR Appeals**
[PO Box 30546] **PO Box 400046**
[Salt Lake City, UT 84130-0546] **San Antonio, TX 78229**

(b) **First and** *[S]*second level **post-service** appeals must be sent in writing to—

UMR Claims Appeal Unit
[PO Box 8086] **PO Box 30546**
[Wausau, WI 54402-8086] **Salt Lake City, UT 84130-0546**

(c) Expedited **pre-service** appeals must be communicated by calling *[UMR telephone (866) 868-7758]* **(800) 808-4424, ext. 15227** or by submitting a written fax to *[(866) 912-8464]* **(888) 615-6584**, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care
Attn: Appeals Department
[550 Maryville Centre, Ste. 300] **8320 Ward Parkway**
[St. Louis, MO 63141] **Kansas City, MO 64114**

(b) Expedited appeals must be communicated by calling *[Coventry Health Care telephone (314) 214-2394]* **(816) 221-8400** or by submitting a written fax to *[(314) 214-3233, Attention: Corporate Appeals]* **(866) 769-2408**.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member *[claimant]* attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the *[claimant]* **member** believes the claim should be paid, and any other written documentation to support the *[claimant's]* **member's** belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Pharmacy Appeals—MH3
Mail Route 0390
6625 W. 78th St.
Bloomington, MN 55439
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

Office of Consumer Information and Oversight
Department of Health and Human Services
PO Box 791
Washington, DC 20044
or by fax to (202) 606-0036
or by email to disputedclaim@opm.gov

(III) The claimant may call the toll-free number (877) 549-8152 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(6) 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.

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's *[date of]* birth **date**.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year**, except that no changes will be considered for High Deductible Health Plan selections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account**. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage**, except that no changes will be considered for High Deductible Health Plan selections after the first MCHCP Health Savings Account contributions has been transmitted for deposit to the subscriber's account**. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(I) Loss of coverage notice—MCHCP may approve **a** late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Lifestyle Ladder]* **Wellness** participation—MCHCP may deny all appeals regarding continuation of participation in the *[Lifestyle Ladder]* **Strive for Wellness** Program due to failure of member's participation.

AUTHORITY: section 103.059, RSMo 2000. 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. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5), adding section (3), and renumbering as necessary.

PURPOSE: This amendment 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, HDHP with HSA, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin*[s]* and nutrient*[s]* coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.

(A) PPO 300, PPO 600, and Medicare Supplement Plan Prescription Drug Coverage.

1. *[Retail—]*Network:

A. Generic **copayment**: Eight*[-]* dollar**s** ($8) *[copayment]* for up to a thirty- (30-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

B. Brand **copayment**: Thirty-five*[-]* dollar**s** ($35) *[copayment]* for up to a thirty- (30-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

C. Non-formulary **copayment**: One hundred*[-]* dollar**s** ($100) *[copayment]* for up to a thirty- (30-) day supply for a drug not on the formulary;

D. Home delivery program—

(I) Maintenance prescriptions may be filled through the home delivery program **or through a retail pharmacy that has agreed to fill maintenance prescriptions at a comparable price to the home delivery program**. Some medications may not qualify for the program because they require prior authorization or quantity level limits.

(a) Generic **copayments**: **Eight dollars ($8) for up to a thirty- (30-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and** *[T]***t**wenty*[-]* dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary**; formulary**

generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

(b) Brand **copayments**: **Thirty-five dollars ($35) for up to a thirty- (30-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and** *[E]*eighty-seven*[-]* dollars and fifty cents ($87.50) *[copayment]* for up to a ninety- (90-) day supply for a brand drug on the formulary**; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**.

(c) Non-formulary **copayments**: **One hundred dollars ($100) for up to a thirty- (30-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and** *[T]*two hundred fifty*[-]* dollars ($250) *[copayment]* for up to a ninety- (90-) day supply for a drug not on the formulary; *[and]*

(II) Select home delivery—

(a) A member must choose how s/he will fill his/her maintenance prescription(s). A member must notify the pharmacy benefit manager of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

(b) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the pharmacy benefit manager of his/her decision, the first two (2) maintenance prescription orders can be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the pharmacy benefit manager of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. Once the pharmacy benefit manager has been notified of the member's decision to purchase his/her maintenance prescription(s) through a retail pharmacy, the retail election remains in place for one (1) year. After one (1) year, the member will be required to make a choice between home delivery and retail pharmacy for maintenance prescriptions; and

(c) Once a member makes his/her delivery election, the member can modify his/her election by contacting the pharmacy benefit manager; and

*[(III)]***(III)** Specialty drugs covered only through network home delivery for up to thirty (30) days. The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic **copayment**: Eight dollars ($8) for **a** generic drug on the formulary list.

(b) Brand **copayment**: Thirty-five dollars ($35) for **a** brand drug on the formulary.

(c) Non-formulary **copayment**: One hundred*[-]* dollar**s** ($100) *[copayment]* for a drug not on the formulary;

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

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

G. If the physician allows for generic substitution and the member chooses a *[brand]* **brand-**name drug, the member is responsible for the generic copayment and the cost difference between the *[brand]* **brand-**name and generic drug; and

H. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%)**,** as prescribed by a physician and included on the formulary **through the pharmacy benefit manager**.

2. *[Retail—]*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 pharmacy *[plan administrator]* **benefit manager**. The pharmacy *[plan administrator]* **benefit manager** will reimburse the cost of the drug based on the network discounted amount **as determined by the pharmacy benefit manager**, less the applicable copayment.

A. Generic **copayment**: Eight*[-]* dollar**s** ($8) *[copayment]* for up to a thirty- (30-) day supply for a generic drug on the formulary.

B. Brand **copayment**: Thirty-five*[-]* dollar**s** ($35) *[copayment]* for up to a thirty- (30-) day supply for a brand drug on the formulary.

C. Non-formulary **copayment**: One hundred*[-]* dollar**s** ($100) *[copayment]* for up to a thirty- (30-) day supply for a drug not on the formulary.

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. *[Retail—]*Network:

A. Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; *[tobacco cessation prescriptions covered at one hundred percent (100%);]* **formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);**

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; *[tobacco cessation prescriptions covered at one hundred percent (100%);]* **formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);**

C. Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program. Some medications may not qualify for the program because they require prior authorization or quantity level limits.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary**; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary*[.]***; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).**

(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary.

(II) Specialty drugs covered only through network home delivery for up to thirty (30) days.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary; and

E. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.

2. *[Retail—]*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 pharmacy *[plan administrator]* **benefit manager**. The pharmacy *[plan administrator]* **benefit manager** will reimburse the cost of the drug based on the network discounted amount **as determined by the pharmacy benefit manager**, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible for up to a thirty- (30-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible for up to a thirty- (30-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible for up to a thirty- (30-) day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other**,** more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a *[first]* **first-**step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the *[first]* **first-**step drug, the physician may request a prior authorization from the pharmacy *[plan administrator]* **benefit manager**. If the prior authorization is approved, the member is responsible for the applicable copayment**,** which may be higher than the *[first]* **first-**step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. *[First]* **First-**step drugs must be used before the plan will authorize payment for *[second]* **second-**step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the *[first]* **first-**step medication;
2. Uses primarily brand-name drugs; and
3. Typically, a higher copayment amount is applicable.

(3) Disease Management Program Reduced Non-Formulary Prescription Copayments—

(A) Members who are actively participating in the Disease Management Program and enrolled in the PPO 300 Plan, PPO 600 Plan, or Medicare Supplement Plan are eligible for a reduced non-formulary prescription copayment as follows:

1. Fifty-five dollars ($55) for up to a thirty- (30-) day supply for a drug not on the formulary;

2. One hundred ten dollars ($110) for up to a sixty- (60-) day supply for a drug not on the formulary; and

3. One hundred thirty-seven dollars and fifty cents ($137.50) for up to a ninety- (90-) day supply for a drug not on the formulary; and

(B) A member is considered actively participating in the Disease Management Program when s/he—

1. Is working one-on-one with a nurse; or

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a nurse until the condition is managed independently; or

3. The medical plan vendor has determined the member does not require one-on-one work with a nurse.

*[(3)]***(4)** Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy *[plan administrator]* **benefit manager**. In order to file a claim, members must—

(A) Complete the claim form;

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

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

(C) Members must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted *[price]* **amount** as determined by the *[vendor minus]* **pharmacy benefit manager, less** any applicable copayment**, deductible, or coinsurance**. Members are responsible for any charge over the network discounted price and the applicable copayment.

*[(4)]***(5)** Formulary—The formulary is updated on a semi-annual basis, or when—

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

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or

(C) A drug is determined to have a safety issue.

*[(5)]***(6)** Grandfathered Specialty Drugs—Prescription drugs grandfathered for members in 2011 because they had taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011, will continue to be covered at a thirty-five-dollar ($35) brand copayment level if enrolled in a PPO plan or at twenty percent (20%) coinsurance if enrolled in the HDHP *[plan]*. Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

(D) Attention-deficit hyperactivity disorder (ADHD);

(E) Biologics for inflammatory conditions;

(F) Cancer drugs;

(G) Hemophilia drugs (factor VIII and IX concentrates);

(H) Hepatitis drugs;

(I) Immunosuppressants (transplant anti-rejection agents);

(J) Insulin (basal);

(K) Low molecular weight heparins;

(L) Multiple sclerosis injectable drugs;

(M) Novel psychotropics (oral products and long-active injectables);

(N) Phosphate binders;

(O) Pulmonary hyperten*[t]*sion drugs; and

(P) Somatostatin analogs.

*[(6)]***(7)** Medicare Part B Prescription Drugs—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 an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:

(A) Diabetes testing and maintenance supplies;

(B) Respiratory agents;

(C) Immunosuppressants; and

(D) Oral anti-cancer medications.

*[(7)]***(8)** Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the Food and Drug Administration and medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

*[(8)]***(9)** Guidelines for Drug Use—If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-2.091 Wellness Program Coverage, Provisions, and Limitations. This rule provided the policy of the board of trustees in regards to the wellness program.

PURPOSE: This rule is being rescinded and readopted as 22 CSR 10-2.120.

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2013, 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 a new wellness program rule that will take effect on January 1, 2013. This rule is being rescinded to avoid two (2) wellness program plan rules from being in effect at the same time. This rule must remain in effect through December 31, 2012, and be rescinded at the end of day on December 31, 2012, to prevent two (2) conflicting rules from being in effect on January 1, 2013. 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 in order to maintain the integrity of the current health care plan and prevent two (2) conflicting wellness program rules from being in effect on January 1, 2013. This emergency rescission must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the MCHCP 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 20, 2010, effective June 30, 2011. Emergency amendment filed Nov 1, 2011, effective Nov. 25, 2011, expires May 22, 2012. Amended: Filed Nov. 1, 2011, effective April 30, 2012. Emergency rescission filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-2.130 Additional Plan Options

PURPOSE: This rule establishes the policy of the board of trustees in regard to the additional plan options provided by Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) Subscribers may choose the PPO 300, PPO 600, High Deductible Health Plan, or Medicare Supplement Plan without coverage for contraception or sterilization if such items or procedures are contrary to his/her religious beliefs or moral convictions.

(2) The PPO 300, PPO 600, High Deductible Health Plan, and Medicare Supplement Plan without coverage for contraception or sterilization are each considered distinct and separate plan options offered by Missouri Consolidated Health Care Plan.

(3) Enrollment in the PPO 300, PPO 600, High Deductible Health Plan, and Medicare Supplement Plan without coverage for contraception or sterilization will be available through the enrollment procedures outlined in 22 CSR 10-2.020. Once a subscriber enrolls in a plan, he/she will be unable to change to another plan during the plan year unless there is a qualifying event.

(4) The PPO 300, PPO 600, High Deductible Health Plan, and Medicare Supplement Plan without coverage for contraception or sterilization will have the same benefit provisions and covered charges as the PPO 300, PPO 600, High Deductible Health Plan, and Medicare Supplement Plan with coverage for contraception or sterilization, except that there is no coverage for contraception or sterilization as either a medical or pharmacy benefit.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080, RSMo Supp. 2012. Emergency rule filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is deleting sections (12), (30), and (44); amending sections (6), (13), (18), (21), (22), (26), (33), (41), (43), (50), (58), (62), (65), and (67); adding sections (38), (68), (69), (73), and (74); and renumbering as necessary.

PURPOSE: This amendment establishes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(6) *[Allowable]* **Allowed** amount. Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed (see balance billing, section (8)).

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

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

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

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

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

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

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

*[(19)]***(18)** Disease management. A program offered to members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

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

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

*[(21)]***(20)** Effective date. The date on which coverage takes effect *[as described in 22 CSR 10-3.020(4)]*.

*[(22)]***(21)** Eligibility date. The first day a member is qualified to enroll for coverage *[as described in 22 CSR 10-3.020(2)]*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

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

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

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

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

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

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

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

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

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

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

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

*[(32)]***(30)** Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager and covered by the plan administrator.

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

*[(34)]***(32)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA.

*[(35)]***(33)** High Deductible Health Plan (HDHP). 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.

*[(36)]***(34)** Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered an illness.

*[(37)]***(35)** Incident. A definite and separate occurrence of a condition.

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

*[(39)]***(37)** Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.

(38) Long-term disability subscriber. A subscriber eligible for long-term disability coverage through a public entity's retirement system.

*[(40)]***(39)** MCHCPid. An individual MCHCP member identifier used for member verification and validation.

*[(41)]***(40)** myMCHCP. A secure MCHCP member website that allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, **retrieve and send secure messages, upload documents,** and access health plan websites.

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

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

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

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

*[(43)]***(42)** *[Medicare-approved]* **Medicare-allowed** amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a health care provider.

[(44) Medicare assignment. When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.]

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

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

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

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

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

*[(50)]***(48)** Participant. Shall have the same meaning as the term member defined herein (see member, section *[(45)]***(43)**).

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

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

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

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

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

*[(56)]***(54)** Primary care physician (PCP). An internist, family/general practitioner, or pediatrician.

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

*[(58)]***(56)** Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010*[(20)]***(19)**. Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

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

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

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

(E) Chiropractor;

(F) Licensed Clinical Social Worker;

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

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

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

*[(60)]***(58)** Public entity. A state-sponsored institution of higher learning, political subdivision, or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.

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

*[(62)]***(60)** Retiree. *[A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(2)(D) and is currently receiving a monthly retirement benefit from a public entity.]* **Notwithstanding any provision of law to the contrary, for the purposes of these regulations a "retiree" is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from an entity-sponsored retirement system.**

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

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

*[(65)]***(63)** Specialty medications. *[High]* **High-**cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

*[(66)]***(64)** State. Missouri.

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

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

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

(68) Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree of a public entity with a retirement system.

(69) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit through a public entity's retirement system.

(73) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits through a public entity's retirement system.

(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 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-3.020 General Membership Provisions. This rule established the policy of the board of trustees in regard to the general membership provisions of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to clarify 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 rescission must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-3.020 General Membership Provisions

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 rule must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency*

*rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) Terms and Conditions. This rule provides the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). Public entities and members are required to provide complete, true, and accurate information to MCHCP in connection with enrollment, change, or cancellation processes, whether by online, written, or verbal communication. MCHCP may rely on, but reserves the right to audit, any information provided by a public entity or member and seek recovery and/or pursue legal action to the extent the public entity or member has provided incomplete, false, or inaccurate information.

(2) Eligibility Requirements.

(A) Active Employee Coverage. An active employee is one who is employed and meets the minimum number of hours worked per year as established by his/her employer.

1. If the public entity allows elected/appointed officials to participate in medical coverage, the definition of an employee includes elected/appointed officials where applicable.

2. The entity will determine the eligibility requirements of waiting periods, required number of working hours, pay status, and contribution levels.

3. An active employee cannot be covered as an employee and as a dependent.

4. A subscriber may enroll eligible dependents as long as the employee is also enrolled subject to the provisions herein.

5. If an active employee has elected coverage as a dependent of another MCHCP subscriber as allowed by these rules, and the subscriber dies before coverage as a dependent goes into effect, the active employee may elect coverage as a subscriber within thirty-one (31) days of the date of death.

6. If one (1) spouse is an active state employee or retiree with MCHCP benefits and the other is an active public entity employee or retiree with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one (1) employer's plan. The spouses cannot have coverage in both places.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is fully vested in the retirement plan upon termination and the public entity remains with MCHCP. The public entity must make the benefits available to all retirees, past and future, who meet the vesting requirements. The employee may elect coverage for him/herself and dependents, provided the employee and any dependents 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 dependents covered) is required.

2. If the retiree's spouse is an active public entity employee or retiree and currently 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.

3. A retiree who returns to employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

4. If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

(C) Survivor Coverage.

1. At the time of the subscriber's death, a survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits and his/her dependents may elect or continue coverage if the survivor and his/her dependents had coverage—

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 subscriber's death. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. A survivor of a retiree or terminated vested subscriber may continue coverage if the survivor had MCHCP coverage as a dependent at the time of the subscriber's death.

3. If a survivor adds a new spouse to his/her coverage and the survivor subsequently dies, the new spouse is no longer eligible for coverage.

4. If a survivor or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

(D) Terminated Vested Coverage.

1. An employee may participate in an MCHCP plan when his/her employment with the public entity terminates if s/he is vested and is eligible for future benefits in a retirement plan with the public entity when s/he reaches retirement age. The employee must elect to continue coverage within thirty-one (31) days of the last day of the month in which his/her employment is terminated. The employee and his/her dependents may elect or continue coverage if the terminated vested employee and his/her dependents had coverage—

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 termination of employment. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. If a terminated vested employee does not elect coverage within thirty-one (31) days of their eligibility date, or if s/he cancels or loses his/her coverage or dependent coverage, the terminated vested employee and his/her dependents cannot enroll at a later date.

3. The terminated vested employee may temporarily continue coverage under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA).

(E) Long-Term Disability Coverage.

1. An employee is eligible for long-term disability coverage if the employee is eligible for long-term disability benefits from the public entity and the employee and his/her dependents may elect or continue coverage if the employee with long-term disability coverage and his/her dependents had coverage—

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 becoming eligible for long-term disability benefits. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. If an enrolled, vested, long-term disability subscriber becomes ineligible for disability benefits, the long-term disability

subscriber and his/her dependents will have continuous coverage as a terminated vested subscriber. If an enrolled long-term disability subscriber is not vested, and becomes ineligible for disability benefits, coverage is terminated and the subscriber and his/her dependents are offered COBRA benefits. If an enrolled long-term disability subscriber becomes ineligible for disability benefits, and returns to work, the subscriber is considered a new employee and must submit a form to enroll.

3. If the employee's spouse is an active state employee or retiree, s/he may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change, as long as coverage is continuous.

(F) Elected/Appointed Official Coverage.

1. If the public entity allows elected/appointed officials to participate in medical coverage, the definition of an active employee includes elected/appointed officials.

(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 covered subscriber or covered 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 of a dependent so long as the parent continues to be covered as a dependent of the subscriber;

(IX) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(X) 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 covered 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.

(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 coverage and/or change coverage levels during the annual open enrollment period.

3. An active employee may apply for coverage for himself/herself and/or for his/her dependents 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; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses 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 dependent 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 dependent, the active employee may enroll the dependent 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 errors, MCHCP will notify the public entity 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.

(B) Retiree Coverage.

1. To enroll or continue coverage at retirement, the employee and his/her dependents 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 with proof of prior medical coverage under a separate group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may add a dependent 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; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her dependent within sixty (60) days if the dependent involuntarily loses 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 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 a dependent. 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 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 add a dependent 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; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses 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 dependent. 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 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 dependent 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; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses 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 dependent. 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 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 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 dependent must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may add a dependent 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; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses 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 dependent. 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 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.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. Unless stated otherwise by these rules, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date and after the waiting period. Except for newborns, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP.

2. The effective date of coverage for a life event shall be as follows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date. The monthly premium is not prorated.

(II) If an active employee enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form;

B. Newborn.

(I) If a subscriber or employee enrolls his/her newborn or a subscriber enrolls a newborn of his/her dependent within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) If a subscriber does not elect to enroll a newborn of a dependent within thirty-one (31) days of birth, s/he cannot enroll the dependent of a dependent at a later date;

C. Adoption or placement for adoption.

(I) If a subscriber or employee enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption;

D. Legal guardianship and legal custody.

(I) If a subscriber or employee enrolls a dependent due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

E. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the subscriber or employee's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

F. Employee.

(I) If an employee enrolls due to a life event, the effective date for the employee is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

3. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

4. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility.

(A) MCHCP reserves the right to request proof of eligibility at any time. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will be terminated or will not take effect.

(B) An employee and/or his/her dependents enrolling due to a loss of other coverage. The employee must submit documentation of proof of loss to MCHCP through his/her public entity Human Resource Department within sixty (60) days of enrollment.

(C) A retiree, survivor, terminated vested subscriber, or long-term disability subscriber enrolling dependents due to a loss of other coverage. The retiree, survivor, terminated vested subscriber, or long-term disability subscriber must submit documentation of proof of loss of coverage for his/her dependents within sixty (60) days of enrollment.

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

(E) The employee is required to notify MCHCP on the appropriate form of the dependent's name, birth date, eligibility date, and Social Security number.

(F) Disabled dependent.

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

A. Evidence that the permanently disabled dependent was entitled to and receiving disability benefits prior to turning age twenty-six (26). Evidence could be from the Social Security Administration, representation from the dependent's physician, or by sworn statement from the subscriber;

B. A letter from the dependent's physician describing the current disability and verifying that the disability predates the dependent's twenty-sixth birthday and the disability is permanent; and

C. A benefit verification letter dated within the last twelve (12) months from the Social Security Administration (SSA) confirming the dependent is still considered disabled by SSA.

2. If a disabled child over the age of twenty-six (26) is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends.

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

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

(6) Military Leave.

(A) Military Leave for an Active Employee.

1. For absences of thirty (30) days or less, coverage continues as if the employee has not been absent.

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for coverage under the Uniformed Services Employment & Reemployment Rights Act (USERRA). The agency payroll representative notifies MCHCP of the effective date of military leave. An employee who is on military leave is eligible for continued coverage for medical, vision, and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment after leave.

3. If the employee is utilizing annual and/or compensatory balances and staying on payroll, the dependent coverage is at the active employee monthly premium.

4. If the employee does not elect to continue USERRA coverage for his/her eligible dependent(s), coverage ends effective the last day of the month in which the leave begins.

5. The employee must submit a form within thirty-one (31) days of the employee's return to work to be reinstated for the same level of coverage with the same plan as prior to the leave. The employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work. The form and the official document must be submitted within sixty (60) days from the date of loss of coverage.

6. Coverage may be reinstated the first of the month in which the member returns to employment, the first of the month after return to employment, or the first of the month after the loss of military coverage.

(B) Military Leave for a Retired Member.

1. A retiree must terminate his/her coverage upon entry into the armed forces of any country by submitting a form and copy of his/her activation papers within thirty-one (31) days of his/her activation date.

2. Coverage will be terminated the last day of the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of his/her separation papers and form within thirty-one (31) days of the separation date.

3. Coverage will be reinstated as of the first of the month in which the employee returns from active duty, the first of the month after the employee returns, or the first of the month after the loss of military coverage.

4. If the retired member fails to reinstate coverage, s/he cannot enroll at a later date.

5. If the retiree terminates his/her coverage, dependent coverage is also terminated.

6. If a retiree does not elect to continue USERRA coverage for his/her eligible dependent(s), coverage ends effective the last day of the month in which the leave begins.

(7) Termination.

(A) Unless stated otherwise, termination of coverage shall occur on the last day of the calendar month coinciding with or after the happening of any of the following events, whichever shall occur first:

1. Failure to make any required contribution toward the cost of coverage;

2. Entry into the armed forces of any country;

3. With respect to active employee(s) and his/her dependents, termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule;

4. With respect to dependents, upon divorce or legal separation from the subscriber or when a child reaches age twenty-six (26), or when a dependent is no longer eligible for coverage. A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. The public entity shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter.

B. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP;

5. Death of dependent. The dependent's coverage ends on the date of death.

A. The public entity shall notify MCHCP of a dependent's death;

6. A member's act, practice, or omission that constitutes fraud or the member makes an intentional misrepresentation of material fact; or

7. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP.

(B) MCHCP may rescind coverage due to non-payment of a premium, fraud, or intentional misrepresentation. MCHCP shall provide at least thirty (30) days written notice before it rescinds coverage.

(C) Termination of coverage shall occur immediately upon discontinuance of the plan, subject to the plan termination provision specified in 22 CSR 10-3.080(1).

(D) If a member receives covered services after the termination of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP to cancel coverage.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the cafeteria plan.

(B) If a member receives covered services after the voluntary cancellation of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(C) A subscriber cannot cancel medical coverage on his/her spouse or step-children during divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce. If premiums are collected pre-tax through a cafeteria plan, medical coverage can only be cancelled at the time of divorce.

(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; or

3. No longer eligible for coverage.

(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 public entity must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form.

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

3. If the employee fails to pay the premium due to the public entity, coverage on the employee and his/her dependents terminates.

4. If the employee's spouse is an active employee or retiree, the employee may transfer coverage under the plan in which the spouse is enrolled. 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.

5. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage in MCHCP while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. For coverage to be reinstated, the employee must submit a completed 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.

6. If the employee chooses to maintain employee coverage but not coverage for his/her covered dependents, the employee is eligible

to regain dependent coverage upon return to work.

(B) Leave of Absence—Family and Medical Leave Act (FMLA).

1. An employee must be approved for a leave of absence under FMLA and meet the requirements and guidelines set forth by FMLA and his/her public entity for his/her employer to continue to pay the monthly contribution toward the employee's and his/her dependents' coverage. Coverage is continuous unless the employee chooses to cancel coverage.

2. If the employee cancels coverage, coverage ends on the last day of the month in which MCHCP received a premium payment.

3. If the employee canceled coverage, the employee may reinstate coverage by submitting a completed form within thirty-one (31) days of returning to work. Coverage will be reinstated with the same plan and level of coverage as enrolled in prior to the employee going out on leave of absence.

4. If the employee continued coverage and is unable to return to work after his/her FMLA leave ends, his/her coverage will be continuous at the retiree rate or the employee may cancel coverage.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

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

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, subscriber may add such eligible dependents to the subscriber's plan if MCHCP is notified within thirty-one (31) days of the marriage, birth, or adoption. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible for Medicare.

4. A surviving spouse and dependents who have coverage due to the death of a non-vested employee may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced or legally-separated spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) own expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

(B) Premium Payments.

1. Initial payment for continuation coverage must be received within forty-five (45) days of election of coverage.

2. After initial premium payment, MCHCP bills on the last working day of the month. There is a thirty-one- (31-) day grace period for payment of regularly scheduled monthly premiums.

3. Premiums for continued coverage will be one hundred two percent (102%) of the total premium for the applicable coverage level. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

(C) Required Notifications.

1. The subscriber or applicable member must notify MCHCP of a divorce, legal separation, a child turning age twenty-six (26), or Medicare entitlement within sixty (60) days of the event date.

2. The human resource/payroll office of the subscriber must notify MCHCP of an employee's death, termination, or reduction of hours of employment.

3. If a COBRA participant is disabled within the first sixty (60) days of COBRA coverage and the disability continues for the rest of the initial eighteen- (18-) month period of continuing coverage, the member must notify MCHCP that s/he wants to continue coverage within sixty (60) days, starting from the latest of: 1) the date on which the SSA issues the disability determination; 2) the date on which the qualifying event occurs; or 3) the date on which the member receives the COBRA general notice. The member must also notify MCHCP within thirty-one (31) days of any final determination that the individual is no longer disabled.

(D) Election Periods.

1. When MCHCP is notified that a COBRA-qualifying event has occurred, MCHCP notifies eligible members of the right to choose continuation coverage.

2. Eligible members have sixty (60) days from the date of coverage loss or notification from MCHCP, whichever is later, to inform MCHCP that they want continuation coverage.

3. If eligible members do not choose continuation coverage within sixty (60) days of lost coverage or notification from MCHCP, coverage ends.

(E) Continuation of coverage may be cut short for any of these reasons—

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

4. The covered employee or dependent becomes entitled to Medicare after the date s/he elects COBRA coverage; or

5. The covered employee or dependent extends coverage for up to twenty-nine (29) months due to disability and there has been a final determination that the individual is no longer disabled.

(F) MCHCP assumes coverage for existing COBRA members until their eligibility period expires or until the public entity terminates coverage with MCHCP, whichever occurs first.

(11) Missouri State Law COBRA Wrap-Around Provisions.

(A) Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) under two (2) conditions—

1. The member continues and maintains coverage under the thirty-six- (36-) month provision of COBRA; and

2. The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay the entire premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium.

(B) For a member to continue coverage under this subsection, a member must either—

1. Within sixty (60) days of legal separation or the entry of a decree of dissolution of marriage or prior to the expiration of a thirty-six- (36-) month COBRA period, the legally-separated or divorced spouse who seeks such coverage shall give MCHCP written notice of the qualifying event, including his/her mailing address; or

2. Within thirty (30) days of the death of an employee whose surviving spouse is eligible for continued coverage or prior to the expiration of a thirty-six (36) month COBRA period, the public entity or surviving spouse shall give MCHCP written notice of the death and the mailing address of the surviving spouse.

(C) Within fourteen (14) days of receipt of the notice, MCHCP shall notify the legally-separated, divorced, or surviving spouse that coverage may be continued. The notice shall include:

1. A form for election to continue the coverage;

2. The amount of premiums to be charged and the method and place of payment; and

3. Instructions for returning the elections form by mail within sixty (60) days after MCHCP mails the notice.

(D) Continuation of coverage terminates on the last day of the month prior to the month the subscriber turns age sixty-five (65). The right to continuation coverage shall also terminate upon the earliest of any of the following:

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The date on which the legally-separated, divorced, or surviving spouse becomes insured under any other group health plan;

4. The date on which the legally-separated, divorced, or surviving spouse remarries and becomes insured under another group health plan; or

5. The date on which the legally-separated, divorced, or surviving spouse reaches age sixty-five (65).

(12) Medicare.

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

(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.

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

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

(14) Communications to Members.

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

(B) A member must notify MCHCP of a change in his/her mailing or email address as soon as possible, but no later than thirty-one (31) days after the change.

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

(D) Failure to update a mailing or email address may result in undeliverable mail/email of important informational material, delayed or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

(15) Deadlines. Unless specifically stated otherwise, MCHCP computes deadlines by counting day one as the first day after the qualifying event. If the last day falls on a weekend or state holiday, the plan administrator may receive required information on the first working day after the weekend or state holiday.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed rescission and 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 10-3.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

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

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

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

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

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

A. Ambulance services for non-emergent use**,** whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism **at initial service. Annual dollar limit may be exceeded with prior authorization**;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

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

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

H. Cochlear implant device;

I. Chelation therapy;

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

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

L. Genetic testing or counseling;

M. Home health care *[and palliative services]*;

N. Hospice care **and palliative services**;

O. Hospital inpatient services except for observation stays;

P. 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;

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

*[Q.]***R.** Nutritional counseling after three (3) sessions annually;

S. Orthognathic surgery;

*[R.]***T.** Orthotics over one thousand dollars ($1,000);

*[S.]***U.** Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

*[T.]***V.** Procedures with codes ending in "T";

*[U.]***W.** Prostheses over one thousand dollars ($1,000);

*[V.]***X.** Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

*[W.]***Y.** Skilled nursing facility;

*[X.]***Z.** Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

*[Y.]***AA.** Transplants**,** including requests related to covered travel and lodging.

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

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

B. Specialty medications;

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. *[The cost of the medication exceeds]* **Medication with costs exceeding** nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications*[.]***; and**

G. Shingles vaccines prescribed by a physician.

3. Prior authorization time frames.

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

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

(B) Concurrent Review—The claims administrator will monitor the medical necessity of *[the]* **an** inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including Medicare, are not subject to this provision; and

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1)–(4).

PURPOSE: This amendment establishes 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.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars ($1,000); family each calendar year, three thousand dollars ($3,000). Non-network: per individual each calendar year, two thousand dollars ($2,000); family each calendar year, six thousand dollars ($6,000).

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

(C) *[During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.]* If the mother is not a Missouri Consolidated Health Care Plan member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(D) Claims shall be paid at ninety percent (90%) if *[required]* **the subscriber requires** 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 local provider approved. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability.

(3) Copayments—set charges for the following services apply as long as network providers are utilized unless otherwise specified. Copayments do not apply to the deductible or out-of-pocket maximum.

(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; **one hundred percent (100%) coverage for routine prenatal office visits and recommended screenings;** lab*[–]***—**covered at one hundred percent (100%); other **services and** diagnostic tests—ninety percent (90%) coinsurance after deductible; Non-network: all services paid at seventy percent (70%) coinsurance after deductible.

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

(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.

(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; *[claims for services paid at one hundred percent (100%);]* charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum *[allowable]* **allowed** amount for transplants performed by a non-network provider.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1)–(4).

PURPOSE: This amendment establishes the policy of the board of trustees in regard to the PPO 2000 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, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars ($2,000); family each calendar year, six thousand dollars ($6,000). Non-network: per individual each calendar year, four thousand dollars ($4,000); family each calendar year, twelve thousand dollars ($12,000).

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

(C) *[During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.]* If the mother is not a Missouri Consolidated Health Care Plan member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(D) Claims shall be paid at eighty percent (80%) if *[required]* **the subscriber requires** 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 local provider approved. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability.

(3) Copayments—set charges for the following services apply as long as network providers are utilized. Copayments do not apply to the deductible or out-of-pocket maximum.

(B) Maternity—Network: primary care—twenty-five dollars ($25) for initial visit, specialist—thirty-five dollars ($35) for initial visit; **one hundred percent (100%) coverage for routine prenatal office visits;** lab—covered at one hundred percent (100%); other diagnostic tests—eighty percent (80%) coinsurance after deductible; Non-network: all services paid at sixty percent (60%) coinsurance after deductible.

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

(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.

(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; *[claims for services paid at one hundred percent (100%);]* charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum *[allowable]* **allowed** amount for transplants performed by a non-network provider.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is deleting sections (7) and (8); amending sections (1)–(3), (5), and (6); adding sections (5) and (6); and renumbering as necessary.

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

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred **fifty** dollars *[($1,200)]* **($1,250)**; family each calendar year, two thousand *[four]* **five** hundred dollars *[($2,400)]* **($2,500)**. Non-network: per individual each calendar year, two thousand *[four]* **five** hundred dollars *[($2,400)]* **($2,500)**; family each calendar year, *[four]* **five** thousand *[eight hundred]* dollars *[($4,800)]* **($5,000)**.

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

*[(A)]***(B)** The family deductible applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered **family** member.

*[(B)]***(C)** *[During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and out-of-pocket maximum. The newborn will be subject to his/her deductible and coinsurance after release from the hospital or if*

s/he is transferred to another hospital.] If the mother is not a*[n]* Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(D) Claims shall be paid at eighty percent (80%) if *[required]* **the subscriber requires** 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 local provider approved. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability.

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

(B) 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 *[claim payment]* **the plan** begins **to pay one hundred percent (100%) of all covered charges** for any covered **family** member.

(C) Network out-of-pocket maximum for individual—two thousand *[four]* **five** hundred dollars *[($2,400)]* **($2,500)**.

(D) Network out-of-pocket maximum for family—*[four]* **five** thousand *[eight hundred]* dollars *[($4,800)]* **($5,000)**.

(E) Non-network out-of-pocket maximum for individual—*[four]* **five** thousand *[eight hundred]* dollars *[($4,800)]* **($5,000)**.

(F) Non-network out-of-pocket maximum for family—*[nine]* **ten** thousand *[six hundred]* dollars *[($9,600)]* **($10,000)**.

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

(5) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.

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

*[(5)]***(7)** A *[member]* **subscriber** does not qualify for the High Deductible Health Plan (HDHP) if *[they are]* **s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (8) of this regulation, is** covered under or enrolled in any *[of]* **other health plan that is not a high deductible health plan, including, but not limited to,** the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

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

(D) Health reimbursement account (HRA); or

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

*[(6)]***(8)** A *[member]* **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.

[(7) Usual, customary, and reasonable fee allowed—Non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.]

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

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2011] **2012**. 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. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

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

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

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

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

(C) *[During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. The newborn will be subject to his/her deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital.]* If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(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.

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

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending section (2), adding sections (2) and (3), and renumbering as necessary.

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

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(2) Transition of Care. A transition of care option is available for members living in the northeast region (which includes the following counties: Adair, Clark, Knox, Linn, Lewis, Macon, Marion, Putnam, Ralls, Schuyler, Scotland, Shelby, and Sullivan) currently using the First Health Network who will be transitioned to the UnitedHealthcare Choice Plus network effective January 1, 2013. A subscriber and his/her dependents using a health care provider who is not part of the UnitedHealthcare Choice Plus network may apply for a ninety- (90-) day transition of care to receive network benefits with his/her current provider for a period of time after January 1, 2013. A subscriber and his/her dependents may apply for additional days beyond the ninety (90) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The request for consideration must be submitted to UMR between October 1, 2012, and January 31, 2013, to be eligible for transition of care benefits. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. If a member is being treated for a condition below by a provider who is not a member of the UnitedHealthcare Choice Plus network, s/he must complete the transition of care form or call UMR directly. Eligible transition of care benefits include:

(A) Upcoming surgery or prospective transplant;

(B) Women in their second or third trimester of pregnancy, or up to eight (8) weeks postpartum;

(C) Women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical cancer trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Being treated as an inpatient at the hospital at the time of the network change;

(N) Any previous treatment for behavioral health; or

(O)Within three (3) months after an acute injury or surgery.

(3) Disease Management.

(A) A non-Medicare subscriber and his/her eligible non-Medicare dependents may participate in a Disease Management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;

2. Diabetes (includes children);

3. Asthma (includes children);

4. Congestive heart failure;

5. Chronic obstructive pulmonary disease;

6. Hypertension; or

7. Depression with one (1) other Disease Management condition.

(B) A member identified as eligible for Disease Management through medical and prescription drug claims will receive an invitation to participate.

*[(2)]***(4)** Covered Charges Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes covered services:

1. Prescribed by an appropriate health care provider for the therapeutic treatment of injury or sickness;

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

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

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

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

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

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

(D) Services in a *[Country Outside of]* **Country Other than** the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Medical plan benefits, limitations, and exclusions**, dated October 30, 2012,** effective January 1, *[2012]* **2013**, are incorporated by reference into this rule and are available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, or online at www.mchcp.org. This rule does not include any later amendments or additions.

(F) Plan benefits for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically-significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially-designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when *[medically necessary and]* other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered *[when medically necessary and]* only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of **direct** observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty**-one** thousand **two hundred sixty-three** dollar *[($40,000)]* **($41,263)** annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit *[are]* **continued to be** medically necessary;

4. Bariatric surgery. *[Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;]* **When specific criteria for bariatric surgery have been met, any of the following open or laparoscopic bariatric surgery procedures are covered when performed at a Centers of Excellence Facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services:**

A. Roux-en-Y gastric bypass;

B. Sleeve gastrectomy;

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

D. Adjustable silicone gastric banding. 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 are covered;

E. Surgical reversal of bariatric surgery is covered when complications of the original surgery (such as stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink or cause vomiting of prescribed meals; or

F. Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss is covered when specific criteria is met. Inadequate weight loss due to individual noncompliance with post-operative nutrition and exercise recommendations is not a medically necessary indication for revision or conversion surgery and is not covered;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

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

*[6.]***7.** Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable *[and medically-necessary]*

services needed to administer the drug or use the device under evaluation in the clinical trial;

*[7.]***8.** Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) *[as medically necessary]* when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve- (12-) week period per incident **without prior authorization**. *[The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;]* **Any visits after the first thirty-six (36) within a twelve- (12-) week period per incident may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary;**

*[8.]***9.** Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

*[9.]***10.** Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. *[The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;]* **Any visits after the first twenty-six (26) may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary;**

*[10.]***11.** Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is 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.

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;

*[11.]***12.** Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. **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.** The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

*[12.]***13.** Durable medical equipment (DME)/medically-necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or *[sickness (illness)]* **illness**. DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

*[13.]***14.** Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If **a member is** admitted to hospital, **s/he** may be required to transfer to network facility for maximum benefit;

*[14.]***15.** Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

*[15.]***16.** Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not *[medically necessary]* **covered** in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

*[16.]***17.** Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered *[as medically necessary]* for an individual recommended for covered heritable genetic testing;

*[17.]***18.** Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

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

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

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

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

*[19.]***20.** 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);

*[20.]***21.** Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. 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.

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

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

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

D. Bone *[Anchored]* **Anchoring** Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

*[21.]***22.** Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

*[22.]***23.** Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (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 (vocational) nurse, licensed therapist, or a registered dietitian;

*[23.]***24.** 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 *[which is]* 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;

*[24.]***25.** Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. 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;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) 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;

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

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

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

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

D. 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:

(I) 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;

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

(III) 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; and

(IV) The attending physician must be a psychiatrist. If the admitting physician 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 physician 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 not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. 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;

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

G. 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:

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

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

(III) A state-licensed psychologist;

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

(V) Licensed professional counselor;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See birth control devices and injections 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 or 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 chemotherapy;

(XX) Intestinal bypass or anastamosis status; and

(XXI) Acquired absence of stomach;

*[25.]***27.** 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;

*[26.]***28.** Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal 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. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

*[27.]***29.** Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program**. Counseling must be** *[when]* ordered by a physician or physician extender and provided by a licensed healthcare professional (e.g., a registered dietitian)*[,]* **for** up to three (3) sessions annually with a registered dietitian*[, with physician order]* **without prior authorization**. *[The maximum]* **Any sessions after the three (3)** may be *[exceeded for an additional three (3) sessions,]* **covered** upon prior authorization by the medical plan, if services *[beyond the maximum limit are]* **continue to be** medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program *[because they are not considered to be medically necessary]*. Conditions for which nutritional evaluation and counseling are not *[considered to be medically necessary include,]* **covered include,** but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

*[28.]***30.** Nutritional therapy. Nutritional therapy is covered when it is**—**

A. *[t]***T**he sole source of nutrition or a significant percentage of the daily caloric intake; *[is]*

B. *[u]***U**sed in the treatment of, or in association with, a demonstrable disease, condition, or disorder; *[is]*

C. *[p]***P**rescribed by a physician; *[is]*

D. *[n]***N**ecessary to sustain life or health; and

E. *[r]***R**equires ongoing evaluation and management by a licensed healthcare provider;

*[29.]***31.** Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan *[being]* provided*[, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable]*;

32. Orthognathic (jaw includes temporomandibular joint and prognathism) surgery is covered for the following specific conditions and when the conditions meet coverage criteria:

A. Acute traumatic injury and post-surgical sequela;

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

C. Obstructive sleep apnea;

D. Cleft lip/palate (for cleft lip/palate related jaw surgery); and

E. Congenital anomalies. Examples of congenital anomalies include: midface hypoplasia, Pierre Robin Syndrome, Hemifacial Microsomia, and Treacher Collins Syndrome;

*[30.]***33.** Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets—covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

*[31.]***34.** Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident**.** *[if showing significant improvement. The maximum may be exceeded,]* **Any visits after the first sixty (60) may be covered** upon prior authorization by the medical plan, if services *[beyond the maximum limit are]* **continue to be** medically necessary;

*[32.]***35.** Preventive services.

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

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

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

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

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. **Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors.** For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza)—The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out of network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a *[medically-necessary]* **covered** preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a *[medically-necessary]* **covered** preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a *[medically-necessary]* **covered** alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

*[33.]***36.** Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related;

*[34.]***37.** Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve- (12-) week period per incident. *[The maximum may be exceeded]* **Any visits after the first thirty-six (36) within a twelve- (12-) week period per incident may be covered**, upon prior authorization by the medical plan, if services *[beyond the maximum limit are]* **continue to be** medically necessary. 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) and/or work;

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

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

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

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

*[35.]***38.** Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

*[36.]***39.** Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation. Direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

*[37.]***40.** Transplants. When neither experimental nor investigational and medically necessary: *[bone marrow]* **stem cell**, kidney, liver, heart, lung, pancreas, *[intestinal]* **small bowel**, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

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

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. 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 not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

[(I) Allogenic bone marrow—one hundred forty three thousand dollars ($143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars ($121,000);

(III) Heart—one hundred twenty-eight thousand dollars ($128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars ($133,000);

(V) Lung—one hundred fifty-one thousand dollars ($151,000);

(VI) Kidney—Fifty-four thousand dollars ($54,000);

(VII) Kidney and pancreas—ninety-seven thousand dollars ($97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars ($153,000);]

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

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

*[39.]***42.** Vision. **One (1)** *[R]***r**outine exam (including refractions)*[. One (1)]* per covered person per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Rescinded and readopted: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013,

*expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Limitations. The Missouri Consolidated Health Care Plan is deleting sections (11), (17), (38), (43), and (47); amending sections (34), (40), and (42); adding sections (5), (31), and (40); and renumbering as necessary.

PURPOSE: This amendment establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(5) Assistive listening device.

*[(5)]***(6)** Assistant surgeon services—not covered unless determined to meet the clinical eligibility for coverage under the plan.

*[(6)]***(7)** Athletic trainer services—services by a licensed athletic trainer not covered.

*[(7)]***(8)** Autopsy.

*[(8)]***(9)** Birthing center.

*[(9)]***(10)** Blood donor expenses—not covered.

*[(10)]***(11)** Blood pressure cuffs/monitors—not covered.

[(11) Blood storage—not covered, including whole blood, blood plasma, and blood products.]

[(17) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.]

*[(18)]***(17)** Educational or psychological testing—not covered unless part of a treatment program for covered services.

*[(19)]***(18)** Examinations requested by a third party.

*[(20)]***(19)** Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

*[(21)]***(20)** Exercise equipment.

*[(22)]***(21)** Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered.

*[(23)]***(22)** Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

*[(24)]***(23)** Services obtained at a government facility—not covered if care is provided without charge.

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

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

*[(27)]***(26)** Home births.

*[(28)]***(27)** Immunizations requested by third party or for travel.

*[(29)]***(28)** Infertility treatment. Services are covered to diagnose the condition.

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

*[(31)]***(30)** Long-term care.

(31) Maxillofacial surgery.

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

[(38) Orthognathic surgery.]

*[(39)]***(38)** Orthoptics.

*[(40)]***(39)** Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. 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. 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. *[Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment, or any late payment charge.]* **No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, filling out paperwork, or late payments.**

(40) 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.

(42) *[Private]* **Private-**duty nursing.

[(43) Prognathic and maxillofacial surgery.]

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

*[(45)]***(44)** Sex therapy.

*[(46)]***(45)** Surrogacy—pregnancy coverage is limited to plan member.

[(47) Temporomandibular Joint Syndrome (TMJ). Services are covered to diagnose the condition.]

*[(48)]***(46)** Travel expenses—not covered except for transplants in a transplant network facility.

*[(49)]***(47)** Workers' *[c]***C**ompensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-3.070 Coordination of Benefits. The Missouri Consolidated Health Care Plan is amending sections (1) and (4).

PURPOSE: This amendment establishes the policy of the board of trustees in regard to the coordination of benefits (COB) in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) If a member is also covered under any other plan (as defined here) and is entitled to benefits or other services for which benefits are **also** payable under Missouri Consolidated Health Care Plan (MCHCP), the benefits under MCHCP will be adjusted as shown in this rule.

(4) Effect on the Benefits of MCHCP. This section applies, which in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

(A) In *[that]* **the** event **that MCHCP is a secondary plan as to one (1) or more other plans**, the benefits of MCHCP**'s PPO plans and High Deductible Plan** may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision **using the following criteria**. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

1. In the case where Medicare is primary for physician and outpatient facility claims, Medicare's allowed amount is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

2. In the case where Medicare is primary for inpatient facility claims, the amount the facility billed is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision. Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicaid paid amount. Effective April 1, 2013, Medicare's allowed amount will be used as MCHCP's allowed amount for inpatient facility claims to determine what MCHCP would have paid in absence of this COB provision and the Medicare paid amount will no longer be combined with the provider's Medicare contractual write off.

3. In the case where another plan is primary, the lower allowed amount of either the primary plan or MCHCP is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

*AUTHORITY: section 103.059, RSMo 2000, and section 103.089, RSMo Supp. [2011] **2012**. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Rescinded and readopted: Filed July 1, 2010, effective Dec. 30, 2010. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (4) and (6).

PURPOSE: This amendment establishes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(4) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage after an individual has been covered under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. *[External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical benefits administered by Coventry Health Care in accordance with state law and regulations promulgated by DIFP.]* The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR**, Coventry Health Care,** and Express Scripts**,** Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect; **or**

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage*[; or]***.**

[C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.]

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her

appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-32.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor *[who will have]* **by** someone *[review the appeal]* who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor *[who will have]* **by** someone *[review the appeal]* who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor *[who will have]* **by** someone *[review the appeal]* who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First **and second** level **pre-service and concurrent claim** appeals must be submitted in writing to—

[UMR Claims Appeal Unit] **UMR Appeals**
[PO Box 30546] **PO Box 400046**
[Salt Lake City, UT 84130-0546] **San Antonio, TX 78229**

(b) **First and** *[S]*second level **post-service** appeals must be sent in writing to—

UMR Claims Appeal Unit
[PO Box 8086] **PO Box 30546**
[Wausau, WI 54402-8086] **Salt Lake City, UT 84130-0546**

(c) Expedited **pre-service** appeals must be communicated by calling *[UMR telephone (866) 868-7758]* **(800) 808-4424, ext. 15227** or by submitting a written fax to *[(866) 912-8464]* **(888) 615-6584**, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care
Attn: Appeals Department
[550 Maryville Centre, Ste. 300] **8320 Ward Parkway**
[St. Louis, MO 63141] **Kansas City, MO 64114**

(b) Expedited appeals must be communicated by calling *[Coventry Health Care telephone (314) 214-2394]* **(816) 221-8400** or by submitting a written fax to *[(314) 214-3233, Attention: Corporate Appeals]* **(866) 769-2408**.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member *[claimant]* attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the *[claimant]* **member** believes the claim should be paid, and any other written documentation to support the *[claimant's]* **member's** belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Pharmacy Appeals—MH3
Mail Route 0390
6625 W. 78th St.
Bloomington, MN 55439
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

Office of Consumer Information and
Oversight
Department of Health and Human Services
PO Box 791
Washington, DC 20044
or by fax to (202) 606-0036
or by email to disputedclaim@opm.gov

(III) The claimant may call the toll-free number (877) 549-8152 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(6) 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.

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's *[date of]* birth **date**.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the *[Missouri State Employees' Cafeteria Plan]* **cafeteria plan**.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the *[Missouri State Employees' Cafeteria Plan]* **cafeteria plan**.

(I) Loss of coverage notice—MCHCP may approve **a** late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

[(J) Lifestyle Ladder participation—MCHCP may deny all appeals regarding continuation of participation in the Lifestyle Ladder Program due to failure of member's participation.]

*[(K)]***(J)** Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

*[(L)]***(K)** Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

*[(M)]***(L)** New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the *[Missouri State Employees' Cafeteria Plan]* **cafeteria plan**.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5); adding section (3); and renumbering as necessary.

PURPOSE: This amendment establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP with HSA of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule 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 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin*[s]* and nutrient*[s]* coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.

(A) PPO 600, PPO 1000, and PPO 2000 Prescription Drug Coverage.

1. *[Retail—]*Network:

A. Generic **copayment**: Eight*[-]* dollar**s** ($8) *[copayment]* for up to a thirty- (30-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

B. Brand **copayment**: Thirty-five*[-]* dollar**s** ($35) *[copayment]* for up to a thirty- (30-) day supply for a brand drug on the

formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

C. Non-formulary **copayment**: One hundred*[-]* dollars ($100) *[copayment]* for up to a thirty- (30-) day supply for a drug not on the formulary;

D. Home delivery program—

(I) Maintenance prescriptions may be filled through the home delivery program **or through a retail pharmacy that has agreed to fill maintenance prescriptions at a comparable price to the home delivery program**. Some medications may not apply for the program because they require prior authorization or quantity level limits.

(a) Generic **copayments**: **Eight dollars ($8) for up to a thirty- (30-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply, and** *[T]***t**wenty*[-]* dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary**; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).**

(b) Brand **copayments**: **Thirty-five dollars ($35) for up to a thirty- (30-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and** *[E]***e**ighty-seven*[-]* dollars and fifty-cents ($87.50) *[copayment]* for up to a ninety- (90-) day supply for a brand drug on the formulary**; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**.

(c) Non-formulary **copayments**: **One hundred dollars ($100) for up to a thirty- (30-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and** *[T]***t**wo hundred fifty*[-]* dollars ($250) *[copayment]* for up to a ninety- (90-) day supply for a drug not on the formulary; *[and]*

(II) Select home delivery—

(a) A member must choose how s/he will fill his/her maintenance prescription(s). A member must notify the pharmacy benefit manager of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

(b) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the pharmacy benefit manager of his/her decision, the first two (2) maintenance prescription orders can be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the pharmacy benefit manager of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. Once the pharmacy benefit manager has been notified of the member's decision to purchase his/her maintenance prescription(s) through a retail pharmacy, the retail election remains in place for one (1) year. After one (1) year, the member will be required to make a choice between home delivery and retail pharmacy for maintenance prescriptions; and

(c) Once a member makes his/her delivery election, the member can modify his/her election by contacting the pharmacy benefit manager; and

*[(II)]***(III)** Specialty drugs covered only through network home delivery for up to thirty (30) days. The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic **copayments**: Eight dollars ($8) for **a** generic drug on the formulary list.

(b) Brand **copayments**: Thirty-five dollars ($35) for **a** brand drug on the formulary.

(c) Non-formulary **copayments**: One hundred-dollars ($100) *[copayment]* for a drug not on the formulary; and

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

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

G. If the physician allows for generic substitution and the member chooses a *[brand]* **brand-**name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and

H. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%)**,** as prescribed by a physician and included on the formulary through the pharmacy benefit **manager**.

2. *[Retail—]*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 pharmacy *[plan administrator]* **benefit manager**. The pharmacy *[vendor]* **benefit manager** will reimburse the cost of the drug based on the network discounted amount **as determined by the pharmacy benefit manager**, less the applicable copayment.

A. Generic **copayment**: Eight*[-]* dollars ($8) *[copayment]* for up to a thirty- (30-) day supply for a generic drug on the formulary.

B. Brand **copayment**: Thirty-five*[-]* dollars ($35) *[copayment]* for up to a thirty- (30-) day supply for a brand drug on the formulary.

C. Non-formulary **copayment**: One hundred*[-]* dollars ($100) *[copayment]* for up to a thirty- (30-) day supply for a drug not on the formulary.

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. *[Retail—]*Network:

A. Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; *[tobacco cessation prescriptions covered at 100%;]* **formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);**

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; *[tobacco cessation prescriptions covered at 100%;]* **formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**;

C. Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary**; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary**; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**.

(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary.

(II) Specialty drugs covered only through network home delivery for up to thirty (30) days.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary*[; and]***.**

(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary; and

E. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.

2. *[Retail—]*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 pharmacy *[plan administrator]* **benefit manager**. The pharmacy *[vendor]* **benefit manager**

will reimburse the cost of the drug based on the network discounted amount **as determined by the pharmacy benefit manager**, less the applicable **deductible or** coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible for up to **a** thirty- (30-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible for up to **a** thirty- (30-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible for up to **a** thirty- (30-) day supply for a drug not on the formulary.

(2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a *[first]* **first-**step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the *[first]* **first-**step drug, the physician may request a prior authorization from the pharmacy *[plan administrator]* **benefit manager**. If the prior authorization is approved, the member is responsible for the applicable copayment**,** which may be higher than the *[first]* **first-**step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. *[First]* **First-**step drugs must be used before the plan will authorize payment for *[second]* **second-**step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the *[first]* **first-**step medication;

2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.

(3) Disease Management Program Reduced Non-Formulary Prescription Copayments—

(A) Members who are actively participating in the Disease Management Program and enrolled in the PPO 600 Plan, PPO 1000 Plan, or PPO 2000 Plan are eligible for a reduced non-formulary prescription copayment as follows:

1. Fifty-five dollars ($55) for up to a thirty- (30-) day supply for a drug not on the formulary;

2. One hundred ten dollars ($110) for up to a sixty- (60-) day supply for a drug not on the formulary; and

3. One hundred thirty-seven dollars and fifty cents ($137.50) for up to a ninety- (90-) day supply for a drug not on the formulary; and

(B) A member is considered actively participating in the Disease Management Program when s/he—

1. Is working one-on-one with a nurse; or

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a nurse until the condition is managed independently; or

3. The medical plan vendor has determined the member does not require one-on-one work with a nurse.

*[(3)]***(4)** Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy *[plan administrator]* **benefit manager**. In order to file a claim, members must—

(A) Complete the claim form;

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

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

(C) Members must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted *[price]* **amount** as determined by the *[vendor minus]* **pharmacy benefit manager, less** any applicable copayment**, deductible, or coinsurance**. Members are responsible for any charge over the network discounted price and the applicable copayment.

*[(4)]***(5)** Formulary—The formulary is updated on a semi-annual basis, or when—

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

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or

(C) A drug is determined to have a safety issue.

*[(5)]***(6)** Grandfathered Specialty Drugs—Prescription drugs grandfathered for members in 2011 because they had taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011, will continue to be covered at a thirty-five-dollar ($35) brand copayment level if enrolled in a PPO plan or at twenty percent (20%) coinsurance if enrolled in the HDHP *[plan]*. Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

(D) Attention-deficit hyperactivity disorder (ADHD);

(E) Biologics for inflammatory conditions;

(F) Cancer drugs;

(G) Hemophilia drugs (factor VIII and IX concentrates);

(H) Hepatitis drugs;

(I) Immunosuppressants (transplant anti-rejection agents);

(J) Insulin (basal);

(K) Low molecular weight heparins;

(L) Multiple sclerosis injectable drugs;

(M) Novel psychotropics (oral products and long-active injectables);

(N) Phosphate binders;

(O) Pulmonary hyperten*[t]*sion drugs; and

(P) Somatostatin analogs.

*[(6)]***(7)** Medicare Part B Prescription Drugs—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 an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:

(A) Diabetes testing and maintenance supplies;

(B) Respiratory agents;

(C) Immunosuppressants; and

(D) Oral anti-cancer medications.

*[(7)]***(8)** Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the Food and Drug Administration and medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

*[(8)]***(9)** Guidelines for Drug Use—If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. 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 10-3.130 Additional Plan Optionss

PURPOSE: This rule establishes the policy of the board of trustees in regard to the additional plan options provided by Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2013, 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 must become effective January 1, 2013, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 30, 2012, becomes effective January 1, 2013, and expires June 29, 2013.*

(1) Subscribers may choose the PPO 600, PPO 1000, PPO 2000, or High Deductible Health Plan without coverage for contraception or sterilization if such items or procedures are contrary to his/her religious beliefs or moral convictions.

(2) The PPO 600, PPO 1000, PPO 2000, and High Deductible Health Plan without coverage for contraception or sterilization are each considered distinct and separate plan options offered by Missouri Consolidated Health Care Plan.

(3) Enrollment in the PPO 600, PPO 1000, PPO 2000, or High Deductible Health Plan without coverage for contraception or sterilization will be available through the enrollment procedures outlined in 22 CSR 10-3.020. Once a subscriber enrolls in a plan, he/she will be unable to change to another plan during the plan year unless there is a qualifying event.

(4) The PPO 600, PPO 1000, PPO 2000, or High Deductible Health Plan without coverage for contraception or sterilization will have the same benefit provisions and covered charges as the PPO 600, PPO 1000, PPO 2000, or High Deductible Health Plan with coverage for contraception or sterilization, except that there is no coverage for contraception or sterilization as either a medical or pharmacy benefit.

AUTHORITY: section 103.059, RSMo 2000, and section 103.080, RSMo Supp. 2012. Emergency rule filed Oct. 30, 2012, effective Jan. 1, 2013, expires June 29, 2013. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*