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SALUS POPULI SUPREMA LEX ESTO

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

Jason Kander

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

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

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

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

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

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

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

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

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

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

EMERGENCY AMENDMENT

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

PURPOSE: This emergency amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2015.

*EMERGENCY STATEMENT: The director of revenue is mandated to establish not later than October 22 annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percent. This emergency amendment is necessary to ensure public awareness and to preserve a compelling governmental interest requiring an early effective date in that the amendment informs the public of the established rate of interest to be paid on unpaid amounts of taxes for the 2015 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, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

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

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

*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, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2070—State Board of Chiropractic Examiners
Chapter 2—General Rules

EMERGENCY AMENDMENT

20 CSR 2070-2.090 Fees. The board is proposing to amend subsection (1)(D).

PURPOSE: The State Board of Chiropractic Examiners is statutorily obligated to enforce and administer the provisions of sections 331.010 to 331.115, RSMo. Pursuant to section 331.070, RSMo, the board shall by rule and regulation set the amount of fees authorized by sections 331.010 to 331.115, RSMo, so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of sections 331.010 to 331.115, RSMo.

EMERGENCY STATEMENT: This emergency amendment is necessary

to preserve a compelling governmental interest requiring an early effective date of the rule by informing the public of a change in the fee required for the renewal of a license. The board is proposing to decrease the license renewal fee from two hundred dollars ($200) to one hundred twenty-five dollars ($125). The emergency amendment is necessary to allow the board to collect the decreased fee. Chiropractors with a license expiration date of February 28, 2015 will be mailed renewal information on or around December 1, 2014 and the decreased fee needs to be reflected in this information. Without this emergency amendment the decreased fee requirement will not be effective in time for the renewal notice and confusion will result in the renewal process.

*The scope of the emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. In developing this emergency amendment, the board has determined that the fee decrease is necessary for the 2015 renewal period to prevent funds from exceeding the maximum fund balance thereby resulting in a transfer from the fund to general revenue as set forth in section 331.070.2, RSMo, "A compelling governmental interest shall be deemed to exist for the purposes of section 536.025, RSMo, for licensure fees to be reduced by emergency rule, if the projected fund balance of any agency assigned to the board of professional registration is reasonably expected to exceed an amount that would require transfer from that fund to general revenue." The board believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed October 27, 2014, becomes effective November 6, 2014, and expires May 4, 2015.*

(1) The following fees hereby are established by the State Board of Chiropractic Examiners:

(D) Renewal Fee
$*[200]***125**

*AUTHORITY: sections 43.543 and 331.100.2, RSMo Supp. [2008] **2014,** and section 331.070, RSMo 2000. This rule originally filed as 4 CSR 70-2.090. Emergency rule filed June 30, 1981, effective July 9, 1981, expired Nov. 11, 1981. Original rule filed June 30, 1981, effective Oct. 12, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 27, 2014, effective Nov. 6, 2014, expires May 4, 2015. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (2), (18), (25), (32), (33), (34), (40), (50), (68), and (75); adding sections (9), (19), (20), and (24); and renumbering as necessary.

PURPOSE: This amendment adds definitions of Behavior Modification Health Coaching, dependent, diabetes education, and eligible variable-hour employee; and clarifies the definitions of: active employee, disease management, employee, health assessment, High Deductible Health Plan, MCHCPid, provider, subscriber, and vendor.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(2) Active employee. A benefit-eligible person employed by the state or agency of the state who meets the plan eligibility requirements. **An eligible variable-hour employee is considered an active employee for the purposes of this chapter.**

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

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

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

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

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

*[(13)]***(14)** 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.

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

*[(15)]***(16)** 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.

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

*[(17)]***(18)** Deductible. The amount the member owes for health care

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

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

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

*[(18)]***(21)** Disease management. *[A program offered to members, who do not have primary Medicare coverage, to help manage certain chronic diseases]* **A multidisciplinary program designed to educate members with chronic diseases to manage their condition(s)**.

*[(19)]***(22)** 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.

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

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

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

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

*[(23)]***(27)** 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.

*[(24)]***(28)** 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.

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

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

*[(27)]***(31)** 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/substance abuse disorder office visits;

(F) Prescription drugs;

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

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

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

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

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

*[(29)]***(33)** 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.

*[(30)]***(34)** 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.

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

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

*[(33)]***(37)** Health [s]**S**avings [a]**A**ccount (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.

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

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

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

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

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

*[(39)]***(43)** 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.

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

*[(41)]***(45)** 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)]***(46)** Medically necessary. The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary treatments, procedures, services, or supplies that the plan administrator or its designee determines, in the exercise of its discretion are—

(A) Expected to be of clear clinical benefit to the member;

(B) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms;

(C) In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;

(D) Not primarily for member or provider convenience; and

(E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms.

*[(43)]***(47)** 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)]***(48)** Medicare Prescription Drug Plan (PDP). The Medicare Prescription Drug Plan, administered by Express Scripts Medicare PDP, is a Medicare Part D Plan with additional coverage to ensure Medicare members have similar benefits to non-Medicare members.

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

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

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

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

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

*[(50)]***(54)** Participant. Shall have the same meaning as the term member defined herein (see member, section *[(45)]* **(49)**).

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

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

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

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

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

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

*[(57)]***(61)** 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)]***(62)** Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(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)]***(63)** Prudent layperson. An individual possessing an average knowledge of health and medicine.

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

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

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

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

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

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

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

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

*[(68)]***(72)** Subscriber. The *[employee or member]* **person** who elects coverage under the plan.

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

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

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

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

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

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

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

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2)–(10).

PURPOSE: This amendment clarifies eligibility requirements and enrollment procedures for active employees, retirees, survivors, terminated vested coverage, long-term disability, and dependent coverage; clarifies effective date provisions; clarifies proof of eligibility requirements; clarifies disabled dependent coverage; clarifies military leave

coverage; clarifies termination requirements; clarifies voluntary cancellation of coverage requirements; clarifies continuance of coverage requirements; clarifies leave of absence coverage; and clarifies Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage requirements.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(2) Eligibility Requirements.

(A) Active Employee Coverage.

1. An active employee may enroll **him/herself and his/her spouse/child(ren)** 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 **or is an eligible variable-hour employee of a MOSERS participating department or agency**. The active employee is eligible to enroll in medical, dental, or vision coverage.

2. An active employee **employed by the Missouri Department of Conservation and** whose position is covered by MOSERS *[and is employed by the Missouri Department of Conservation]* **or who is an eligible variable-hour employee** may only *[participate]* **enroll him/herself and his/her spouse/child(ren)** in an MCHCP dental or vision plan.

3. An active employee **employed by the Missouri Department of Transportation or Highway Patrol** may *[participate]* **only enroll him/herself and his/her spouse/child(ren)** 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) **or is an eligible variable-hour employee**.

4. If an active employee has *[elected coverage]* **been enrolled** 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]* **his/her spouse/child(ren)**, provided the employee and *[any dependents]* **his/her spouse/child(ren)** have been continuously covered for health care benefits—

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

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

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

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

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

4. If the retiree's spouse is a state active employee or retiree and *[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.]***5.** If a retiree *[or his/her dependents]* who *[are]* **is** eligible for coverage elect**s** not to be continuously covered **for him/herself and spouse/child(ren)** with MCHCP from the date first eligible, or do**es** not apply for coverage **for him/herself and spouse/child(ren)** within thirty-one (31) days of *[their]* **his/her** eligibility date, the*[y]* **retiree and his/her spouse/child(ren)** shall not thereafter be eligible for coverage **unless specified elsewhere herein**.

*[7.]***6.** An individual enrolled in another non-MCHCP Medicare Prescription Drug Plan (Part D) is not eligible for medical coverage.

(C) Survivor Coverage.

1. At the time of *[the]* **a vested active employee** subscriber's death, *[a]* **his/her** survivor**(s)** *[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]* **to** continue coverage if the survivor**(s)** *[and his/her dependents]* had **MCHCP** coverage*[—]* **at the time of the subscriber's death. The deceased subscriber's spouse/child(ren) who do not have MCHCP coverage at the time of the death may elect MCHCP coverage and become a survivor if the spouse/child(ren) 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. T]***t**hrough group or individual medical coverage for the six (6) months immediately prior to **the** subscriber's death. **In that case, *[P]*p**roof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of *[dependents]* **persons** covered) is required.

2. A**t the time of a retiree or terminated vested subscriber's death, his/her** survivor**(s)** *[of a retiree or terminated vested subscriber]* may **elect to** continue coverage if the survivor**(s)** had

MCHCP coverage *[as a dependent]* at the time of the subscriber's death.

3. If a survivor **subsequently marries and elects to** add*[s]* **his/her** *[a]* new spouse to his/her coverage and the survivor *[subsequently]* dies, the new spouse**'s** *[is no longer eligible for]* coverage **ends at midnight on the last day of the month of the survivor's death (e.g., If the survivor dies November 3, new spouse's last day of coverage is November 30). Unless otherwise specified in this rule, the new spouse is not eligible to enroll for coverage at the time of the survivor's death**.

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 after the first day of the month following the death of the employee, s/he cannot enroll at a later date.]* **If there are multiple survivors, once enrolled, the spouse will become the subscriber or, if there are only children, the youngest enrolled child will become the subscriber.**

[A. Medicare enrolled survivors will continue to be enrolled at the same level of coverage following the death of the subscriber.]

(D) Terminated Vested Coverage.

1. An **active** employee may *[participate]* **enroll him/herself and his/her spouse/child(ren)** 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]* **spouse/child(ren)** 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]* **persons** 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 **for him/herself and his/her dependents** 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 **or spouse/child(ren)** 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]* **persons** 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) **Terminated Non-Vested** Elected State Official Coverage.

1. **Terminated non-vested elected state officials (including** *[M]***m**embers of the General Assembly **and**, state officials holding *[a]* statewide office**)**, *[or]* **terminated non-vested** employees of *[members of the General Assembly or]* **elected** state officials and *[his/her]* **their** dependents may continue coverage in an MCHCP plan if employment terminates because the *[member of the General Assembly or]* **elected** state official ceases to hold elected office. The elected state official or his/her employees must elect to continue coverage for *[him/herself]* **themselves** and dependents within thirty-one (31) days from the last day of the month in which *[his/her]* employment is terminated. If the *[subscriber]* **elected state official or his/her employees** do**(**es**)** not elect coverage **for him/herself and dependents** within thirty-one (31) days, cancels, or loses his/her coverage or dependent coverage, the *[subscriber]* **elected state official or his/her employees** 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 **or child of a dependent when paternity by the dependent is established after birth** 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 or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

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

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

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

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

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

B. Employer-sponsored group coverage loss. An employee and his/her *[dependents]* **spouse/child(ren)** 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]* **spouse/child(ren)** loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

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

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

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

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

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

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

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

(B) Retiree Coverage.

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

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

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

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

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

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

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

B. Employer-sponsored group coverage loss. A retiree may enroll his/her *[dependent(s)]* **spouse/child(ren)** within sixty (60) days if the *[dependent(s)]* **spouse/child(ren)** 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 **him/herself and his/her spouse/child(ren)** within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

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

5. If a retiree **with Medicare** is *[currently]* enrolled in the PPO 300 *[or PPO 600]* Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO *[600]* **300** Plan provided through the vendor the retiree is *[currently]* enrolled in, effective the first day of the next calendar year.

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

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

*[A.]***C.** If a retiree is *[currently]* enrolled in the *[High Deductible Health Plan]* **HSA Plan** and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the *[High Deductible Health Plan]* **HSA Plan** at the same level of coverage.

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

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

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

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

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

(C) Terminated Vested Coverage.

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

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

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

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her *[dependent(s)]* **spouse/child(ren)** within sixty (60) days if the *[dependent(s)]* **spouse/child(ren)** 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]* **spouse/child(ren)**. If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber **without Medicare** is *[currently]* enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents 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.

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

retiree is enrolled in, effective the first day of the next calendar year.

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

*[A.]***C.** If a terminated vested subscriber is *[currently]* enrolled in the *[High Deductible Health Plan]* **HSA Plan** and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the *[High Deductible Health Plan]* **HSA Plan effective the first day of the next calendar year,** at the same level of coverage.

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

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

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

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

(D) Long-Term Disability Coverage.

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

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

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

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her *[dependent(s)]* **spouse/child(ren)** within sixty (60) days if the *[dependent(s)]* **spouse/child(ren)** 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]* **spouse/child(ren)**. If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber **without Medicare** is *[currently]* enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents 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.

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

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

*[A.]***C.** If a long-term disability subscriber is *[currently]* enrolled in the *[High Deductible Health Plan]* **HSA Plan** and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the *[High Deductible Health Plan]* **HSA Plan** at the same level of coverage.

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

*[B.]***D.** If a long-term disability subscriber is *[currently]* enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan **effective the first day of the next calendar year,** at the same level of coverage.

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

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

(E) Survivor Coverage.

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

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

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

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

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

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

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

B. Employer-sponsored group coverage loss. A survivor may enroll his/her *[dependent(s)]* **spouse/child(ren)** within sixty (60) days if the *[dependent(s)]* **spouse/child(ren)** 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]* **spouse/child(ren)**. If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor **without Medicare** is *[currently]* enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents 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.

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

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

*[A.]***C.** If a survivor is *[currently]* enrolled in the *[High Deductible Health Plan]* **HSA Plan** and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the *[High Deductible Health Plan]* **HSA Plan** at the same level of coverage.

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

*[B.]***D.** If a survivor is *[currently]* enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the TRICARE Supplemental Plan **effective the first day of the next calendar year,** at the same level of coverage.

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

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

(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. A new employee/**eligible variable-hour employee** and his/her dependents' coverage begins on the first day of the month after enrollment through SEBES **or another designated enrollment system**. Except at initial employment **or when identified as an eligible variable-hour employee**, 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. **In no case, shall an eligible variable-hour employee and his/her dependents' coverage begin before January 1, 2015.**

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 **unless enrollment is received on the first day of a month, in which case coverage is effective on that day**;

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]* **newborn** of a dependent at a later date;

C. Child where paternity is established after birth. If a subscriber enrolls a child within thirty-one (31) days of the date paternity is established, 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;

*[C.]***D.** 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.]***E.** 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.]***F.** 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.]***G.** Employee.

(I) If an employee enrolls due to a life event **or loss of employer-sponsored coverage**, 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 thirty-one (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 **or loss of employer-sponsored coverage**.

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 **by the plan**, 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 **or loss of employer-sponsored coverage**.

7. For continuous coverage, an active employee who terminates employment with the state may transfer coverage of him/herself and his/her dependents to his/her spouse who is an MCHCP subscriber if the spouse completes an Enroll/Change/Cancel form within thirty-one (31) days of coverage termination of the active employee's employment.

*[7.]***8.** 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 **or loss of employer-sponsored coverage**.

*[8.]***9.** 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.]***10.** 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]* **spouse/child(ren)** 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.]* **When enrolling a newborn,** *[T]***t**he 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]* **initiate** 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]* **begin** unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date; 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)] **Addition of biological child(ren)**	Government-issued birth certificate or other government-issued or legally-certified proof of *[eligibility]* **paternity** listing subscriber as parent and *[newborn's]* **child'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)	**Order of** *[P]***p**lacement papers in subscriber's care
Adoption of dependent(s)	*[Adoption papers; Placement papers; or]* **Order of placement; or** Filed petition for adoption listing subscriber as adoptive parent **(documentation must be received with the enrollment forms) and final adoption decree or a birth certificate issued (documentation must be received within thirty-one (31) days of the date the court enters a final decree of adoption).**
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] **Addition of a child(ren)** of covered dependent	Government-issued birth certificate or legally-certified proof of *[eligibility]* **paternity** for *[newborn]* **the child(ren)** listing *[covered]* dependent as parent with *[newborn's]* **child'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]* **persons** covered
TRICARE Supplemental Coverage	Military ID Card

(C) An active employee, retiree, terminated vested subscriber, long-term disability subscriber, or survivor and all eligible *[dependents]* **spouse/child(ren)** 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]* **spouse/child(ren)** 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]* **his/her spouse/child(ren)** 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]* **spouse/child(ren)** within sixty (60) days of enrollment.

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

(G) Disabled Dependent.

1. A new employee may enroll his/her permanently disabled *[dependent]* **child** or a**n** *[currently]* enrolled permanently disabled dependent turning age twenty-six (26) years may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the 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]* **child**:

A. Evidence that the permanently disabled dependent **or child** was entitled to and receiving disability benefits prior to turning age twenty-six (26) years. Evidence could be from the Social Security Administration, representation from the dependent's **or child's** physician, or by sworn statement from the subscriber;

B. A letter from the dependent's **or child's** physician describing the current disability and verifying that the disability predates the dependent's **or child'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]* **child** is still considered disabled by SSA.

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

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

(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 **or if the employee was on military leave during open enrollment or while on military leave had a qualifying life event, the employee may change plans and add his/her spouse/child(ren)**. 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 **and his/her dependents** 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 active employee(s) and his/her dependents, the employer has determined that the active employee is no longer an eligible variable-hour employee;

*[4.]***5.** 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 **enrolled ex-**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 or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

*[5.]***6.** 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.]***7.** A member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact; *[or]*

*[7.]***8.** A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP*[.]***; or**

9. A member otherwise loses benefit eligibility.

(8) Voluntary Cancellation of Coverage.

(C) A subscriber cannot cancel medical coverage on his/her *[spouse or children]* **dependents** 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*[.]***; or**

4. When new coverage is taken through other employment.

(9) Continuation of Coverage.

(A) Leave of Absence.

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

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

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

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

5. If the employee chooses to maintain employee coverage but not coverage for his/her *[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]* **taking the** leave of absence**. If the employee was on FMLA leave during MCHCP's annual open enrollment, or if while the employee was on FMLA leave, the employee had a qualifying life event or loss of employer-sponsored coverage, the employee may change plans and add a spouse/child(ren) within thirty-one (31) days of returning to work**.

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.

(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]* **spouse/child(ren)** 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]* **spouse/child(ren)** 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]* dependent*[s]* who *[have]* **has** 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 **enrolled** spouse and *[dependents]* **stepchild(ren)** 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 and the disability continues during the rest of the initial eighteen- (18-) month period of continuation of coverage, the member may continue coverage for up to an additional eleven (11) months.

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

(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.

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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (4), (5), and (6); and

adding sections (3), (4), and (5); and renumbering as necessary.

PURPOSE: This amendment clarifies employee contributions for active employees; adds language regarding contributions for FMLA leave of absence members, terminated vested members, and long-term disability members; clarifies contributions for retirees; clarifies Medicare Prescription Drug Only Plan contributions for retirees and survivors; adds language regarding monthly bills for employee's checks that are not sufficient to cover his/her premium; clarifies direct bill of premiums; and clarifies premium payment deductions.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(1) Total premium costs for various levels of *[employee coverage]* are based on employment status, **retiree status,** eligibility for Medicare, and various classifications of dependent participation as established by the plan administrator.

(2) The *[employee's contribution toward total premium]* **Missouri Consolidated Health Care Plan (MCHCP) contribution toward the premium for active employee coverage** shall be determined by the plan administrator.

(3) The MCHCP contribution toward the premium for Family Medical Leave Act (FMLA) leave of absence coverage shall be the same as for active employees.

(4) The MCHCP shall not make a contribution toward the premium for terminated vested (including terminated non-vested elected state officials and employees), leave of absence (except for FMLA leave of absence), foster parents, or Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage.

(5) The MCHCP contribution toward the premium for long-term disability coverage shall be equal to the amount that was contributed toward the comparable rate tier in 2002.

*[(3)]***(6)** The Missouri Consolidated Health Care Plan (MCHCP) contribution toward *[the]* retiree *[premium for members enrolled in the PPO 300, PPO 600, and the High Deductible Health Plan]* **coverage** is based on either of the following:

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

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

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

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

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

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

greater of the amount calculated in subsection (3)(A) or the flat dollar amount that was contributed in 2002.

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

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

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (4)(A) is compared to *[fifty-two percent (52%)]* **fifty-three percent (53%)** of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (4)(A) or *[fifty-two percent (52%)]* **fifty-three percent (53%)** of the Medicare Prescription Drug Only Plan.

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

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

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

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

3. If a subscriber owes past-due premiums, the payroll deductions for current premiums along with the payroll deductions for past-due premiums will be divided equally and taken from the subscriber's future payrolls as follows:

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

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

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

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

E. Three hundred one dollars ($301) to four hundred dollars ($400) will be deducted from five (5) payrolls;

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

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

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

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

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

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

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

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

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

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

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

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

C. If a subscriber owes past-due premiums, payroll deductions for current premiums along with the payroll deductions for past-due premiums will be divided equally and taken from the subscriber's future payrolls as follows:

(I) One hundred dollars ($100) or less, deduction will be taken from one (1) payroll;

(II) One hundred one dollars ($101) to three hundred dollars ($300) will be deducted from two (2) payrolls;

(III) Three hundred one dollars ($301) to five hundred dollars ($500) will be deducted from three (3) payrolls;

(IV) Five hundred one dollars ($501) to seven hundred dollars ($700) will be deducted from four (4) payrolls;

(V) Seven hundred one dollars ($701) to nine hundred dollars ($900) will be deducted from five (5) payrolls; and

(VI) Nine hundred one dollars ($901) and over will be deducted from six (6) payrolls.

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

(C) Retirees and Survivors Premiums From Benefit Check.

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

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

(D) Direct Bill *[for non-Medicare Consolidated Omnibus Budget Reconciliation Act (COBRA), Long-Term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members]* **of Premium Owed By Subscribers Whose Premium is not Deducted from Payroll or Benefit Check**.

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

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

[(E) Direct Bill for Medicare Primary Consolidated Omnibus Budget Reconciliation Act (COBRA), Long-Term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members.

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

(F) ACH Electronic Payment of Premiums for COBRA, Long-Term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members.]

*[1.]***A.** *[Medical, dental, and vision p]***P**remiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental, and vision premiums).

*[2.]***B.** If there are insufficient funds, MCHCP will *[send]* **bill** the subscriber *[a letter and bill requesting payment]* **for the premium owed. The due date of the premium owed shall not change due to insufficient funds**.

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

(A) By enrolling in coverage under MCHCP, a**n** *[subscriber]* **active employee** agrees that MCHCP may deduct the member's contribution toward the total premium from the subscriber's paycheck. Payment for the first month's premium is made by payroll deduction. Double deductions may be taken to pay for the first month's coverage depending on the date the enrollment is received and the effective date of coverage. Subsequent premium payments are deducted from the *[subscriber's payroll]* **active employee's paycheck. If the active employee's check is not sufficient to cover his/her premium, the active employee agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP**.

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

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

[2. If coverage terminates on the retiree, survivor, vested, or COBRA subscriber or his/her dependents, the subscriber cannot enroll in the plan at a later date. The subscriber is responsible for claims submitted after the termination date.]

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

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

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

AUTHORITY: section 103.059, RSMo 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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 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 clarifies requirements for prior authorization of services, including: procedure codes ending in "T", bariatric surgery, and medications; adds a prior authorization requirement for hearing aids; clarifies retrospective review; and adds language regarding pre-determination of coverage and case management.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and*

parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.

(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]* **denied for payment**. Members who have another primary carrier, including Medicare, are not subject to this provision **except for those services that are not covered by the other primary carrier, but are otherwise subject to prior authorization under this rule**. Prior authorization does not verify eligibility or payment. Prior authorizations *[based on]* **found to have** a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition *[will not]* **may** be *[covered]* **rescinded**.

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) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service;

D. Auditory brainstem implant (ABI);

E. Bariatric *[procedures]* **surgery**;

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. Hearing Aids;

*[M.]***N.** Home health care;

*[N.]***O.** Hospice care and palliative services;

*[O.]***P.** Hospital inpatient services *[except for observation stays]*;

*[P.]***Q.** 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;

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

*[R.]***S.** Nutritional counseling after *[three (3)]* **six (6)** sessions annually;

*[S.]***T.** Orthognathic surgery;

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

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

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

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

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

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

*[Z.]***AA.** 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

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

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

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail **or the mail order** pharmacy*[, 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 **at retail or the mail order pharmacy**; and

3. Prior authorization timeframes.

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 ninety (90) 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;

(C) Retrospective Review—Reviews *[conducted after]* **to determine coverage after** services have been provided to a patient. The retrospective review *[does not include the review of a claim that]* is **not** limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment. **The claim administrator shall have the authority to correct payment errors when identified under retrospective review.**

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment.

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface with providers, and negotiate care.

Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.

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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 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), (2), (3), (4), and (7).

PURPOSE: This amendment clarifies member responsibility for newborn claims, adds language regarding nutritional counseling; clarifies the out-of-pocket maximum; clarifies who the subscriber is if both spouses have children enrolled; and clarifies copayments for mental health office visits.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(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).

(C) *[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]* **If the mother is a Missouri Consolidated Health Care Plan (MCHCP) member, the claim(s) for the newborn's initial hospitalization will be covered at one hundred percent (100%) until discharge or transfer to another facility**.

(D) If the mother is not an MCHCP member, the newborn's claims will be subject to his/her own deductible and coinsurance.

(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.

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible **is met**. Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out-of-network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.

(F) Nutritional counseling—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after deductible is met.

(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.*

*[(A)] [N]***n**etwork and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

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

*[(C)]***(B)** Network out-of-pocket maximum for individual—one thousand three hundred seventy-five dollars ($1,375).

*[(D)]***(C)** Network out-of-pocket maximum for family—two thousand seven hundred fifty dollars ($2,750).

*[(E)]***(D)** Non-network out-of-pocket maximum for individual—two thousand seven hundred fifty dollars ($2,750).

*[(F)]***(E)** Non-network out-of-pocket maximum for family—five thousand five hundred dollars ($5,500).

*[(G)]***(F)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include**, but are not limited to**: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed *[amount for transplants performed by a non-network provider]*.

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

(7) Copayments**.***[—set charges for the following services apply*

as long as network providers are utilized.] Copayments do not apply to the deductible.

(A) Office visit—primary care: twenty-five dollars ($25); **mental health: twenty-five dollars ($25);** specialist: forty dollars ($40); chiropractor office visit and/or manipulation: twenty dollars ($20); urgent care: fifty dollars ($50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

1. Vision office visit or refraction: forty dollars ($40);

2. Hearing test—performed by a primary care provider: twenty-five dollars ($25); performed by a specialist: forty dollars ($40).

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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 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), (2), (3), and (4); adding section (7); and renumbering as necessary.

PURPOSE: This amendment clarifies member responsibility for newborn claims; clarifies the out-of-pocket maximum; clarifies who the subscriber is if both spouses have children enrolled; adds nutritional counseling benefit information; and adds an emergency room visit copayment.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(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).

(C) *[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.]* **If the mother is a Missouri Consolidated Health Care Plan (MCHCP) member, the claim(s) for the newborn's initial hospitalization will be covered at one hundred percent (100%) until discharge or transfer to another facility.**

(D) 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.

(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.

(E) Preventive care—Network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible **is met**. Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out-of-network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.

(F) Nutritional Counseling—Network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after deductible is met.

(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.*

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

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

*[(C)]***(B)** Network out-of-pocket maximum for individual—one thousand five hundred dollars ($1,500).

*[(D)]***(C)** Network out-of-pocket maximum for family—three thousand dollars ($3,000).

*[(E)]***(D)** Non-network out-of-pocket maximum for individual—three thousand dollars ($3,000).

*[(F)]***(E)** Non-network out-of-pocket maximum for family—six thousand dollars ($6,000).

*[(G)]***(F)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include**, but are not limited to**: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed *[amount for transplants performed by a non-network provider]*.

(4) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security *[N]***n**umber (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a

dependent. If both spouses have children enrolled the spouse with *[a birthday occurring first in the calendar year]* **the higher Social Security number (SSN)** will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(7) Copayments—Copayments do not apply to the deductible.

(A) Emergency room—one hundred dollars ($100) network and non-network. Deductible and coinsurance are applied in addition to the copayment. If a member is admitted to the hospital, the copayment is waived.

*[(7)]***(8)** Usual, customary, and reasonable limit fee allowed—non-network medical claims are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor.

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

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

*[(10)]***(11)** Services received while out of the country may be covered if the service is included in 22 CSR 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.053 *[High Deductible]* **Health** ***Savings Account*** **Plan Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is amending the title, purpose, and sections (1), (2), (3), (4), (10), (11), (12), and (14).

PURPOSE: This amendment revises the title, purpose, and section (8) to reflect the High Deductible Health Plan name change; clarifies member responsibility for newborn claims; adds nutritional counseling benefit information; clarifies who the subscriber is if both spouses have children enrolled; clarifies that medical and pharmacy expenses contribute to the plan out of pocket maximum; clarifies Health Savings Account Plan eligibility; and clarifies Health Savings Account contributions.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the [High Deductible Health Plan] ***Health Savings Account (HSA) Plan,*** *benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.*

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(1) Deductible amount—Network: per individual each calendar year, one thousand six hundred fifty dollars ($1,650); family each calendar year, three thousand three hundred dollars ($3,300). Non-network: per individual each calendar year, four thousand dollars ($4,000); family each calendar year, eight thousand dollars ($8,000).

(C) *[If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the n]***N**ewborn's claims will be subject to deductible and coinsurance *[during the hospital admission]*.

(D) Medical and pharmacy expenses are combined to apply toward the network or non-network deductible amount, as appropriate.

(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.

(E) Preventive care—Network claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible **is met**. Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.

(F) Nutritional counseling—Network claims are paid at one hundred percent (100%) after deductible is met. Non-network claims are paid at sixty percent (60%) coinsurance after deductible is met.

(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.*

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

non-network benefits.

*[(B)]***(A)** The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member.

*[(C)]***(B)** Network out-of-pocket maximum for individual—three thousand three hundred dollars ($3,300).

*[(D)]***(C)** Network out-of-pocket maximum for family—six thousand six hundred dollars ($6,600).

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

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

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

(G) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

(H) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

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

(10) A subscriber does not qualify for the *[High Deductible Health Plan (HDHP)]* **HSA Plan** if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (13) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(E) *[The member has veteran's benefits that have been used within the past three (3) months.]* **If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.**

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

(12) If a subscriber **and/or his/her dependent(s)** is enrolled in the *[HDHP]* **HSA Plan** and his/her status changes to Medicare primary during the plan year, the subscriber must enroll in the PPO 300 Plan or PPO 600 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.

[(A) Medicare eligible dependents of non-Medicare retired subscribers are not eligible for the High Deductible Health Plan.]

(14) Health Savings Account (HSA) Contributions.

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

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

(B) The MCHCP contributions will be deposited into the subscriber's HSA *[bi-annually on the Friday after the first Thursdays in January and July]* as follows:

1. Deposits are generally made the first Monday of the month, or the first working day after the first Monday if the first Monday is a holiday.

Deposit	Subscriber Only	All other coverage levels
January	$150.00	$300.00
April (delayed contribution due to health care FSA *[balance]* **grace period**)	$150.00	$300.00
July	$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]* **an applicable** prorated *[bi-annual]* contribution. *[A subscriber will not be able to voluntarily change his/her plan selection after the bi-annual contribution has been deposited into the subscriber's HSA.]* **Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.**

(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]* **an applicable** prorated *[bi-annual]* contribution based on the increased level of coverage.

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

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2013] ***2014****. 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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (4); removing section (3); and renumbering as necessary.

PURPOSE: This amendment revises the name of the High Deductible Health Plan; removes language regarding disease management requirements; removes language regarding member responsibility for mother and newborn claims; clarifies the plans to which the benefits in this rule apply; clarifies transition of care requirements; clarifies hearing aid benefits; clarifies injections and infusion benefits; clarifies nutritional counseling benefits; and clarifies transplant expense benefits; and adds diabetic education benefits.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

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

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. 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 subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the *[same]* fee *[as]* paid **as allowed by any applicable secondary network agreements or the fee as paid to the provider** prior to leaving the network**, whichever is lesser**. Benefits eligible for transition of care include:

[(3) Disease Management.

(A) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in an UMR plan 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 non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in a Coventry plan 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 with one (1) other disease management condition; or
7. Depression with one (1) other disease management condition.

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

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

(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 services:

1. Prescribed by an appropriate 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.

(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 provider visit to seek a second opinion.

(D) Services in a 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) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and *[HDHP]* **HSA Plan** are as follows:

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

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

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

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

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

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

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

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

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

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

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

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

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

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

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

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

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

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

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

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: routine allergy re-testing is not considered medically necessary;

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

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and

Quality Improvement Program (MBSAQIP);

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

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

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

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

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

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

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

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

C. All of the following criteria have been met:

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

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

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

I. Type II diabetes;

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

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

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

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

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

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

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

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

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

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

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

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

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

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

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

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

A. Genetic or hereditary hemochromatosis;

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

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

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

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

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

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

J. Cystinuria;

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

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

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

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

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

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

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

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

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

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

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

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

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

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

[E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;]

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

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

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

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

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

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

(I) National Institutes of Health (NIH);

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

(III) Agency for Health Care Research and Quality;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Radiologic evidence of cochlear ossification;

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

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

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

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

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

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

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

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

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

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

12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

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

13. Diabetic Education when prescribed by a provider and taught by a Certified Diabetes Educator through a network provider.

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

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

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

(I) Colostomy and ureterostomy bags;

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

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

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

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

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

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

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

*[15.]***16.** 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;

*[16.]***17.** Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

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

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

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

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

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

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

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

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

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

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

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

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

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

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

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

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

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

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

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

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

*[18.]***19.** Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). 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;

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

*[20.]***21.** 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);

*[21.]***22.** 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. Prior to receiving a hearing aid members must receive—

(I) A comprehensive exam by a qualified provider which includes case history, visual inspection pure-tone screening and screening by self-assessment of hearing disability; and

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

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

*[A.]***(I)** Conventional: one thousand dollars ($1,000).

*[B.]***(II)** Programmable: two thousand dollars ($2,000).

*[C.]***(III)** Digital: two thousand five hundred dollars ($2,500).

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

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

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

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

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

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

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

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

F. A home health care visit is defined as—

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

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

(I) Homemaker or housekeeping services;

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

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

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

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

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

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

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

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

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

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

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

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

*[25.]***26.** Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

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

(a) Cornea transplant;

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

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

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

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

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

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

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

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

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

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

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services 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; and

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

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

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

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

(c) A state-licensed psychologist;

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

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

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

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition *[or]* **of** alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastamosis status;

(XXI) Acquired absence of stomach; *[and]*

(XXII) Pancreatic insufficiency; and

*[(XXII)]***(XXIII)** Ideopathic progressive polyneuropathy;

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

*[28.]***29.** Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after 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. Newborns covered by the PPO 300 or PPO 600 Plan will be subject to deductible and coinsurance if mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance;]*

*[29.]***30.** 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 ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services 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]* **is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian)**;

*[30.]***31.** Nutrition therapy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) Anteroposterior Discrepancies—

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

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

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

(II) Vertical Discrepancies—

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

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

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

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

(III) Transverse Discrepancies—

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

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

(IV) Asymmetries—

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

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

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

*[34.]***35.** Orthotics.

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

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

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

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

I. Member is covered for AFO; and

II. Additional knee stability is required; and

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

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

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

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

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

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

(II) AFO and KAFO Not Used During Ambulation.

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

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

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

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

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

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

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

VII. Member has plantar fasciitis.

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

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

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

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

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

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

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an

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

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

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

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

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

(I) Orthopedic footwear;

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

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

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

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

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

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

(a) Acute plantar fasciitis;

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

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

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

(g) Medial osteoarthritis of the knee;

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

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

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

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

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

(a) Hallux valgus deformities;

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

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

(d) Structural deformities such as tarsal coalitions; or

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

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

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

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

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

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

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

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

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

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

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

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

J. Orthopedic Footwear for Diabetic Members.

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

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

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

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

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

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*[35.]***36.** 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 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. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

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

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

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

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

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

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

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

*[38.]***39.** Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

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

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

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

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

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

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

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

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

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

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

(b) Grade II or worse spondylolisthesis; or

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

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

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

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

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

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

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

B. Occupational therapy must meet the following criteria:

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

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

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

C. Speech therapy.

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

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

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

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one

supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

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

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

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

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. **The transplant recipient must be with the travel companion or parents(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined** *[T]***t**ravel **and lodging expenses** *[is]* **are** limited to a ten thousand dollar ($10,000) maximum per transplant.

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

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

(III) Meals—not covered.

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

(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);

*[43.]***44.** Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

*[44.]***45.** Vision. One (1) routine exam and refractions is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is removing section (1); amending sections (4), (5), and (6); and renumbering as necessary.

PURPOSE: This amendment adds facsimile numbers for appeal submissions for both UMR and Coventry Health Care of Kansas, Inc.; clarifies the Coventry Health Care of Kansas, Inc.'s plan name; clarifies Express Script's appeals address; adds language regarding the Pharmacy Lock-In Program; adds facsimile and website information for appeals sent to the Missouri Consolidated Health Care Plan Board of Trustees; revises the name of the High Deductible Health Plan; clarifies plan change requirements for the HSA Plan; clarifies Health Care Provider Form appeals; clarifies that payment in full must be included with the appeal; and clarifies the timeframe for submitting an appeal to enroll due to late notification of loss of coverage.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

[(1) General Provision. The board of trustees has the right to suspend, revise, or remove eligibility and benefit requirements in the case of a disaster or emergency situation.]

*[(2)]***(1)** Claims Submissions and Initial Benefit Determinations for Medical and Non-Medicare Primary Pharmacy Services.

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously-approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously-approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider, or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based, with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

*[(3)]***(2)** General Appeal Provisions for Medical and Non-Medicare Primary Pharmacy Services.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave rise to the appeal.

*[(4)]***(3)** Appeal Process for Medical and Non-Medicare Primary 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. 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 **of Kansas, Inc.**, 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*[.]***; and**

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;

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.

(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 by someone 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 by someone 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 by someone 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 Appeals
PO Box 400046
San Antonio, TX 78229
or by fax to (888) 615-6584

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

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care **of Kansas, Inc.**—

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

Coventry Health Care **of Kansas, Inc.**
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
or by fax to (866) 769-2408

(b) Expedited appeals must be communicated by **calling** (913) 202-5000 or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy **and the Pharmacy Lock-In Program** consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals**. Pharmacy appeals and Pharmacy Lock-In Program appeals** must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, **and any applicable reason(s) relevant to the appeal including:** the reason**(s)** the member believes the claim should be paid, **the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program,** and any other written documentation to support the 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 BL0390
6625 W. 78th St.
Bloomington, MN 55439]
Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

Express Scripts
Drug Utilization Review Program
100 Parsons Pond Dr.
Franklin Lakes, NJ 07417-2603

*[(III)]***(IV)** 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.

(V) The pharmacy benefit manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the pharmacy benefit manager 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—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number (888) 866-6205 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 timeframe 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.

*[(5)]***(4)** Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by *[fax or letter to the following address]* **sending or uploading the written appeal to one (1) of the following**:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110
or by fax to (866) 346-8785
or online at www.mchcp.org

*[(6)]***(5)** In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines**. Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction**:

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn or the newborn of an enrolled dependent retroactively to the date of birth if the *[initial request is made in writing to the board of trustees]* **appeal is received** within three (3) months of the child's birth date. Valid proof of eligibility must be included with the appeal *[for the request to be considered]*;

(B) MCHCP may approve a subscriber's appeal and not hold the subscriber responsible when there is credible evidence that there has been an error or miscommunication through the subscriber's payroll/personnel office, MCHCP, or MCHCP vendor that was no fault of the subscriber;

(C) MCHCP may approve an appeal to change the type of medical or vision plan that the subscriber elected **or defaulted to** during the annual open enrollment period if the request is made 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]* **Health Savings Account (HSA) Plan** elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. This guideline may not be used to elect or cancel coverage or to enroll or cancel dependents. 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;

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account*[. The subscriber must include payment in full for all past and current premiums due for reinstatement]*;

(E) MCHCP may approve a subscriber's appeal to terminate dental and/or vision coverage if the appeal is received within thirty-one (31) calendar days of the beginning of the new plan year and if no claims have been made or paid during the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(F) MCHCP may approve an appeal regarding late receipt of proof-of-eligibility documentation if the subscriber can provide substantiating evidence that it took an unreasonable amount of time for the government agency creating the documentation to provide subscriber with requested documentation;

(G) MCHCP may approve an appeal to change a subscriber's medical plan coverage level prospectively, if the appeal 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]* **HSA 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;

(H) MCHCP may approve a subscriber's appeal to enroll after a deadline due to late notice of loss of coverage from subscriber's previous carrier if the appeal is *[timely from]* **within sixty (60) days of the** date of late notice;

(I) MCHCP may approve appeals, other than those relating to nonpayment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period;

(J) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier**, except that no changes will be considered for HSA Plan elections 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;

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancelation or an appeal of a deadline that is statutorily mandated;

(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment; and

(M) MCHCP may approve appeals of a late submission of a *[Preventive Lab form]* **Health Care Provider Form** if the subscriber can provide substantiating evidence that the *[preventive lab screening]* **annual wellness exam** was received timely, that the subscriber reasonably relied on the health care provider to submit the *[Preventive Lab form]* **Health Care Provider Form** *[to the wellness vendor]*, and the health care provider failed to submit the *[Preventive Lab form]* **Health Care Provider Form** *[to the wellness vendor]* prior to the May 31 due date.

*[(7)]***(6)** Medicare Primary Pharmacy Appeals.

(A) Appeals rights and procedures for Medicare primary pharmacy services are provided as regulated by the Centers for Medicare and Medicaid Services. Members may contact the Pharmacy Employer Group Waiver Plan vendor, Express Scripts, for additional information on appeal rights and procedures.

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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

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

PURPOSE: This amendment clarifies a member's total yearly costs during the initial coverage stage, the coverage gap stage, and the catastrophic coverage stage; and adds language regarding prescription drugs covered at one hundred percent (100%).

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

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

(A) The following Medicare primary members enrolled in the PPO 300, PPO 600, or the Medicare Prescription Drug Only Plan shall receive their pharmacy benefit through the Medicare Prescription Drug Plan:

1. Active employee members that have Medicare primary coverage and their *[enrolled]* dependents that have Medicare primary coverage; and

2. Retiree members that have Medicare primary coverage and their *[enrolled]* dependents that have Medicare primary coverage.

(C) Foster parent members that have Medicare primary coverage and their *[enrolled]* dependents that have Medicare primary coverage will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

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

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

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[two thousand eight hundred fifty*

dollars ($2,850)] **two thousand nine hundred sixty dollars ($2,960)**, the member will pay the following copayments:

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

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

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

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[two thousand eight hundred fifty dollars ($2850)]* **two thousand nine hundred sixty dollars ($2,960)** and remain below *[four thousand five hundred fifty dollars ($4,550)]* **four thousand seven hundred dollars ($4,700)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[four thousand five hundred fifty dollars ($4,550)]* **four thousand seven hundred dollars ($4,700)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[four thousand five hundred fifty dollars ($4,550)]* **four thousand seven hundred dollars ($4,700)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[two dollar and fifty-five cent ($2.55)]* **two dollar and sixty-five cent ($2.65)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or a *[six dollar and thirty-five cent ($6.35)]* **six dollar and sixty cent ($6.60)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage;

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

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

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

1. Prescribed Vitamin D for all ages:

A. The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D2 or D3 per dose;

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

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

4. Formulary contraception and non-formulary contraception when the provider determines a generic is not medically appropriate or a generic version is not available.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending the purpose and sections (1), (2), and (5); and removing sections (3), (6), (8), and (9); and renumbering as necessary.

PURPOSE:This amendment revises the name of the High Deductible Health Plan; adds language regarding the specialty split-fill program; clarifies language regarding coverage of compounds; clarifies language regarding drugs covered at one hundred percent (100%); removes language regarding formulary contraception; clarifies language regarding prescriptions filled at a non-network facility; clarifies the prescription out-of-pocket maximum; clarifies the step therapy program; removes language regarding the Disease Management Program; removes language regarding grandfathered specialty drugs; removes language regarding guidelines for drug use; and removes language regarding the Affordable Care Act required zero dollar drugs.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300, PPO 600, [HDHP with HSA and Medicare Supplement Plans] ***and Health Savings Account Plan*** *of the Missouri Consolidated Health Care Plan.*

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

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

(A) PPO 300 and PPO 600.

1. Network:

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

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

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

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

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

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

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

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

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

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for **an** up to thirty-one- (31-) day supply **unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply**. The first specialty prescription order may be filled through a retail pharmacy**, except for those select drugs that have been included in the specialty split-fill program**.

(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 dollars ($100) for a drug not on the formulary;

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

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

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

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

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

(I) Prescribed Vitamin D for all ages;

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

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

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

[(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.]

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

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

[A. Generic copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply for a drug not on the formulary.]

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

A. Network and non-network out-of-pocket maximums are *[not]* separate;

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

charges received by one (1) family member may only meet the individual out-of-pocket maximum amount;

C. Individual—*[six thousand two hundred fifty dollars ($6,250)]* **five thousand one hundred dollars ($5,100)***;*

D. Family—*[twelve thousand five hundred dollars ($12,500)]* **ten thousand two hundred dollars ($10,200)**.

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

1. Network:

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

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

C. Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

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

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

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.

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

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

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs covered only through network home delivery for up to thirty-one (31) days.

(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

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

(I) Prescribed Vitamin D for all ages;

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

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

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

[(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available].

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

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

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

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

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

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

(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-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-step drug, the physician may request a prior authorization from the PBM. If the prior authorization is approved, the member is responsible for the applicable copayment, which may be higher than the 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-step drugs must be *[used]* **attempted** before the plan will authorize payment for second-step drugs.

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

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

1. Fifty-five dollars ($55) for up to a thirty-one- (31-) 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 DM Program when s/he is enrolled in a DM Program through the medical plan vendor and one (1) of the following:

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

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a DM nurse until the medical plan vendor determines the condition can be managed independently; or

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

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

(A) Complete the claim form;

(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) A member 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 amount as determined by the PBM, less any applicable copayment, deductible, or coinsurance. A member is responsible for any charge over the network discounted price and the applicable copayment.

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

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

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

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

[(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. 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 hypertension drugs; and

(P) Somatostatin analogs.]

*[(7)]***(5)** Quantity Level Limits. Quantities of some medications may be limited based on recommendations by the FDA or credible scientific evidence published in peer-reviewed medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

[(8) 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.

(9) Affordable Care Act (ACA) required zero dollar drugs. The following drugs are covered at one hundred percent (100%) coverage:

(A) Prescribed over-the-counter nicotine replacement;

(B) Non-formulary brand contraceptive when the individual's health care provider determines that the covered generic would be medically inappropriate for that individual; and

(C) Non-formulary brand contraceptive when a generic version does not exist for one (1) of the FDA-approved contraceptive methods such as barrier, hormonal, or implanted devices.]

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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.095 TRICARE Supplement Plan. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment reflects the name change of the TRICARE Supplement Plan vendor.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(1) TRICARE is the Department of Defense's health insurance program for the military community. Primary coverage is through TRICARE with the *[Missouri Consolidated Health Care Plan]* TRICARE Supplement Plan paying secondary on claims.

(A) TRICARE Supplement Plan design is defined and provided by *[the Association and Society Insurance Corporation (ASI)]* **Selman & Company**.

(B) TRICARE Supplement Plan eligibility, enrollment, and termination requirements are determined by *[ASI]* **Selman & Company**.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Original rule filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2)–(7).

PURPOSE: This amendment clarifies eligibility requirements and enrollment procedures for foster parent and dependent coverage; clarifies enrollment procedures; proof of eligibility requirements; clarifies disabled dependent coverage; clarifies qualifying events for termination; clarifies COBRA coverage; and clarifies voluntary cancellation of coverage.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(2) Eligibility Requirements.

(A) Foster Parent Coverage. The Department of Social Services shall provide appropriate documentation to MCHCP of initial and ongoing eligibility of a foster parent who qualifies for the purchase of *[state health insurance]* **MCHCP coverage**. Documentation of eligibility for the purchase of *[state health insurance]* **MCHCP coverage** shall be required prior to enrollment. A foster parent may enroll *[dependents]* **his/her spouse/child(ren)** as long as the foster parent is also enrolled. In order to be eligible, a foster parent shall not have access to other health insurance coverage through an employer or spouse's employer.

(B) Dependent Coverage. Eligible dependents include:

1. Spouse. If both spouses are eligible foster parents, each spouse must enroll separately;

2. Children.

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

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

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

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent *[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 **when paternity by the dependent is established after birth** so long as the *[newborn's]* parent continues to be covered as a dependent of the subscriber; or

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

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

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

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP 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 or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) An eligible foster parent must enroll for coverage within thirty-one (31) days from the date of the letter notifying the foster parent of his/her eligibility to enroll. If enrolling *[dependents]* **spouse/child(ren)**, proof of eligibility must be submitted as defined in section (5).

(C) An eligible foster parent may apply for coverage for himself/herself and/or for his/her *[dependents]* **spouse/child(ren)** if one (1) of the following occurs:

1. 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 eligible foster parent's responsibility to notify MCHCP of the life event;

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

2. Employer-sponsored group coverage loss. An eligible foster parent and his/her *[dependents]* **spouse/child(ren)** may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

A. Employer-sponsored medical, dental, or vision plan terminates;

B. Eligibility for employer-sponsored coverage ends;

C. Employer contributions toward the premiums end; or

D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

3. If an eligible foster parent or his/her *[dependent]* **spouse/child(ren)** loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for coverage of *[dependent]* **a child**, the eligible foster parent may enroll the *[dependent]* **child** in an MCHCP plan within sixty (60) days of the court order; or

5. If an eligible foster parent is *[currently]* enrolled and does not complete enrollment during the open enrollment period, the foster parent and his/her *[dependents]* **spouse/child(ren)** will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the foster parent is *[currently]* enrolled in, effective the first day of the next calendar year; or

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

(4) Effective Date Provisions. In no circumstances can the effective date be before the eligibility date or before January 1, 2013. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Eligible Foster Parent and Dependent Effective Dates.

1. Unless stated otherwise by these rules, an eligible foster parent 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 eligible foster parent 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 eligible foster parent 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. Child where paternity is established after birth. If a subscriber enrolls a child due to establishment of paternity within thirty-one (31) days of the date paternity is established, 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;

*[C.]***D.** Adoption or placement for adoption.

(I) If a subscriber or eligible foster parent 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.]***E.** Legal guardianship and legal custody.

(I) If a subscriber or eligible foster parent enrolls a *[dependent]* **child** 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.]***F.** Foster care.

(I) If a subscriber or eligible foster parent enrolls a foster child due to placement in the subscriber or eligible foster parent'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.]***G.** Eligible Foster Parent.

(I) If an eligible foster parent enrolls due to a life event, the effective date for the eligible foster parent 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 eligible foster parent *[and his/her eligible dependent(s)]* who elects coverage and/or changes coverage levels **for him/herself and his/her spouse/child(ren) or dependents** during open enrollment shall have an effective date of January 1 of the following year.

4. If a foster parent gains state employment, s/he must enroll as a new state employee.

5. 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]* **spouse/child(ren)** 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. Failure to provide the required documentation within the above stated time frames will result in the *[dependent]* **spouse/child(ren)** being ineligible for coverage until the next open enrollment period;

2. *[Coverage is provided for a newborn of a member from the moment of birth.]* **When enrolling a newborn,** *[T]***t**he 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]* **initiate** 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]* **begin** unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the date of birth. 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; and]

*[4.]***3.** Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
[Birth of dependent(s)] **Addition of biological child(ren)**	Government-issued birth certificate or other government-issued or legally-certified proof of *[eligibility]* **paternity** listing subscriber as parent and *[newborn's]* **child'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)	**Order of** *[P]***p**lacement *[papers in subscriber's care]*
Adoption of dependent(s)	*[Adoption papers; Placement papers; or]* **Order of placement; or** Filed petition for adoption listing subscriber as adoptive parent **(documentation must be received with the enrollment forms) and final adoption decree or birth certificate issued (documentation must be received within thirty-one (31) days of the date the court enters a final decree of adoption).**
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] **Addition of a child(ren)** of covered dependent	Government-issued birth certificate or legally-certified proof of *[eligibility]* **paternity** for *[newborn]* **the child(ren)** listing *[covered]* dependent as parent with *[newborn's]* **child'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]* **persons** covered

(B) An eligible foster parent and his/her *[dependents]* **spouse/child(ren)** enrolling due to a loss of employer-sponsored group coverage. The foster parent must submit documentation of proof of loss within sixty (60) days of enrollment. Failure to provide the required documentation within the above stated time frames will result in the foster parent and his/her *[dependents]* **spouse/child(ren)** being ineligible for coverage until the next open enrollment period.

(C) The eligible foster parent is required to notify MCHCP on the appropriate form of the *[dependent's]* **spouse/child's** name, date of birth, eligibility date, and Social Security number.

(D) Disabled Dependent.

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

A. Evidence that the permanently disabled dependent **or child** was entitled to and receiving disability benefits prior to turning

age twenty-six (26). Evidence could be from the Social Security Administration (SSA), representation from the dependent's **or child's** physician, or by sworn statement from the subscriber*[.]***;**

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

C. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the *[dependent]* **child** is still considered disabled by SSA.

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

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

(6) 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 premium payment for 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 **and his/her dependents** 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. Loss of foster parent licensure as determined by the Department of Social Services;

3. With respect to dependents, upon divorce or legal separation from the subscriber or when a *[child]* **dependent** reaches age twenty-six (26). A subscriber must terminate coverage for his/her **enrolled ex-**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 or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

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

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

6. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP; *[or]*

7. A subscriber has obtained access to other health insurance coverage through an employer or spouse's employer*[.]***; or**

8. A member otherwise loses benefit eligibility.

(7) Voluntary Cancellation of Coverage.

(C) A subscriber cannot cancel medical coverage on his/her *[spouse or children]* **dependents** 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.

(D) A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents if they are no longer eligible for coverage **or when new coverage is taken through other employment.**

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

(A) Eligibility. In accordance with COBRA, eligible foster parents 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 eligible foster parents and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Eligible foster parents voluntarily or involuntarily ending licensure as a foster parent (for reasons other than gross misconduct) 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]* **spouse/child(ren)** 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 **his/her** eligible *[dependents]* **spouse/child(ren)** during open enrollment.

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

4. A surviving *[spouse and]* dependent*[s]*, who *[have]* **has** coverage due to the death of an eligible foster parent, may elect coverage for up to thirty-six (36) months at their own expense.

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

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

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage and the disability continues during the rest of the initial eighteen (18) month period of continuation of coverage, the member may continue coverage for up to an additional eleven (11) months.

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

*AUTHORITY: section 103.059, RSMo 2000, and section 103.078, RSMo Supp. [2013] **2014**. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. Amended: Filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY RULE

22 CSR 10-2.150 Disease Management Services Provisions and Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regards to the disease management services including the disease management program, the disease management incentive, and the diabetes management incentive; and the method and timeframes in which the requirements of the incentive must be completed.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo

coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(1) Disease management services include: disease management, disease management incentive, and the diabetes management incentive. Disease management is administered through MCHCP's disease management vendor. The disease management incentive and the diabetes management incentive are administered through the MCHCP Pharmacy Benefit Manager in conjunction with Missouri Consolidated Health Care Plan's (MCHCP) disease management vendor. Participation in any of the disease management services is voluntary. Eligible members are responsible for enrolling, participating, and completing requirements by the applicable deadlines outlined in this rule.

(2) Disease Management.

(A) Eligibility—The following members enrolled in a MCHCP Preferred Provider Organization (PPO) or Health Savings Account (HSA) Plan are eligible to participate in disease management (DM):

1. Non-Medicare subscribers; and

2. Non-Medicare dependents of DM eligible subscribers.

(B) Limitations and Exclusions—The following members are not eligible to participate in DM:

1. Subscribers with Medicare primary coverage;

2. Dependents with Medicare primary coverage;

3. TRICARE Supplement Plan subscribers;

4. Dependents of DM ineligible subscribers;

5. When Medicare becomes a DM eligible subscriber's primary insurance payer, the subscriber and DM eligible dependent(s) are no longer eligible to participate and will lose the incentives the first day of the month in which Medicare becomes primary; and

6. When Medicare becomes a DM eligible dependent's primary insurance payer, the DM eligible dependent is no longer eligible to participate and will lose the incentives the first day of the month in which Medicare becomes primary.

(C) An eligible member may participate in a DM program appropriate for managing a chronic condition if s/he meets the relevant age criterion and has one (1) or more of the following chronic conditions:

1. Asthma—open to those aged six (6) and over;

2. Cancer—open to those aged eighteen (18) and over;

3. Chronic obstructive pulmonary disease—open to those aged eighteen (18) and over;

4. Congestive heart failure—open to those aged eighteen (18) and over;

5. Coronary artery disease—open to those aged eighteen (18) and over;

6. Depression—open to those aged eighteen (18) and over;

7. Diabetes—open to those aged six (6) and over;

8. Musculoskeletal/chronic pain (including low back pain)—open to those aged eighteen (18) and over;

9. Obesity (Body Mass Index $\geq$ 30)—open to those aged eighteen (18) and over; or

10. Hypertension as a co-morbid condition to any of the chronic conditions listed herein—open to those aged eighteen (18) and over.

(D) A member identified as eligible for DM through medical and prescription drug claims evaluated by MCHCP's DM vendor will receive an invitation to participate in DM from the DM vendor.

(E) A member can self-identify to the DM vendor with a provider's written statement that includes the member's diagnosis of a DM-eligible chronic condition.

(F) For the purposes of this rule, a member is considered actively participating in DM when s/he is enrolled in a DM program through MCHCP's DM vendor and one (1) of the following occurs:

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

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

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

(3) Disease Management Incentive.

(A) Members actively participating in DM are eligible to receive the respective reduced non-formulary prescription copayment or coinsurance:

1. PPO 600 Plan or PPO 300 Plan members—

A. Fifty-five dollars ($55) copayment for up to a thirty-one- (31-) day supply at a network retail pharmacy;

B. One hundred ten dollars ($110) copayment for up to a sixty- (60-) day supply at a network retail pharmacy;

C. One hundred sixty-five dollars ($165) copayment for up to a ninety- (90-) day supply at a network retail pharmacy;

D. One hundred thirty-seven dollars and fifty cents ($137.50) copayment for up to a ninety- (90-) day supply filled through the home delivery program;

2. HSA Plan members—

A. Thirty percent (30%) coinsurance after deductible has been met at a network pharmacy.

(B) Members actively participating in DM on December 1, 2014 will receive the DM Incentive through January 31, 2015 to allow the member to enroll and begin active participation in the 2015 DM program.

(4) Diabetes Management Incentive.

(A) Members with a diagnosis of diabetes confirmed through either claims data or through a provider's certification must complete the following to be eligible to receive the diabetes management incentive:

1. Enroll in the diabetes DM program through MCHCP's DM vendor; and

2. Actively participate in diabetes DM.

(B) Members actively participating in diabetes DM are eligible to receive:

1. Reduced prescription drug copayment or coinsurance for prescriptions directly related to the treatment of diabetes and the listed diabetic supplies at one hundred percent (100%) as specified:

A. PPO 300 Plan or PPO 600 Plan members—

(I) Formulary generic copayment: Four dollars ($4) for up to a thirty-one- (31-) day supply; eight dollars ($8) for up to a sixty- (60-) day supply; twelve dollars ($12) for up to a ninety- (90-) day supply through a network retail pharmacy or ten dollars ($10) for up to a ninety- (90-) day supply through home delivery.

(II) Formulary brand copayment: Seventeen dollars and fifty cents ($17.50) for up to a thirty-one- (31-) day supply; thirty-five dollars ($35) for up to a sixty- (60-) day supply; fifty-two dollars and fifty cents ($52.50) for up to a ninety- (90-) day supply

through a network retail pharmacy or forty-three dollars and seventy-five cents ($43.75) for up to a ninety- (90-) day supply through home delivery.

(III) Non-formulary brand copayment: fifty dollars ($50) for up to a thirty-one- (31-) day supply; one hundred dollars ($100) for up to a sixty- (60-) day supply; one hundred fifty dollars ($150) for up to a ninety- (90-) day supply through a network retail pharmacy or one hundred twenty-five dollars ($125) for up to a ninety-day- (90-day) supply through home delivery.

(IV) Glucometer received at a network pharmacy covered at one hundred percent (100%), one per plan year.

(V) Formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%).

B. HSA Plan members—

(I) Formulary generic coinsurance: Five percent (5%) after deductible;

(II) Formulary brand coinsurance: Ten percent (10%) after deductible;

(III) Non-formulary coinsurance: twenty percent (20%) after deductible;

(IV) Glucometer, received at a network pharmacy covered at one hundred percent (100%) after deductible, one per plan year.

(V) Formulary test strips and lancets received at a network pharmacy covered at one hundred percent (100%) after deductible.

2. Three (3) visits with a certified diabetes educator when prescribed by a provider and received through a network provider are covered at one hundred (100%) for PPO Plan members or at one hundred percent (100%) after deductible is met for HSA Plan members.

(5) The incentives will start no later than thirty (30) days after active participation begins.

(6) Eligible members failing to actively participate in DM will lose the disease management incentive or the diabetes management incentive and will become ineligible for the respective incentive(s) for the remainder of the year.

(7) Audit—MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from DM, loss of the disease management incentive and the diabetes management incentive, and/or prosecution.

(8) Coordination of programs—MCHCP and its DM vendor may utilize participation data for purposes of offering additional programs in accordance with MCHCP's privacy policy.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. 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 amending sections (18), (33), (39), (47), (48), (67), and (72); and adding sections (18) and (19); and renumbering as necessary.

PURPOSE: This amendment adds definitions of dependent and diabetes education; and clarifies the definitions of: disease management, employee, High Deductible Health Plan, MCHCPid, provider, and vendor.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

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

(19) Diabetes education. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

*[(18)]***(20)** Disease management. *[A program offered to members, who do not have primary Medicare coverage, to help manage certain chronic diseases.]* **A multidisciplinary program designed to educate members with chronic diseases to manage their condition(s)**.

*[(19)]***(21)** 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.

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

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

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

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

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

(B) Serious impairment to a bodily function;

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

(D) Inadequately controlled pain; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) Prescription drugs;

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

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

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

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

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

*[(29)]***(31)** 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.

*[(30)]***(32)** 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.

*[(31)]***(33)** 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.

*[(32)]***(34)** 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.

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

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

*[(35)]***(37)** Incident. A definite and separate occurrence of a condition.

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

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

*[(38)]***(40)** Long-term disability subscriber. A subscriber eligible for long-term disability coverage through a public entity's retirement system.

*[(39)]***(41)** MCHCPid. An individual MCHCP *[member]* **subscriber** identifier used for member verification and validation.

*[(40)]***(42)** 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.

*[(41)]***(43)** Medically necessary. The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary treatments, procedures, services, or supplies that the plan administrator or its designee determines, in the exercise of its discretion are—

(A) Expected to be of clear clinical benefit to the member;

(B) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a member's illness, injury, mental illness, substance use disorder, disease, or its symptoms;

(C) In accordance with generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;

(D) Not primarily for member or provider convenience; and

(E) Not more costly than an alternative service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of member's illness, injury, disease, or symptoms.

*[(42)]***(44)** 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.

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

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

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

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

*[(47)]***(49)** 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.

*[(48)]***(50)** Participant. Shall have the same meaning as the term member defined herein (see member, section *[(43)]* **(45)**).

*[(49)]***(51)** 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.

*[(50)]***(52)** 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.

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

*[(52)]***(54)** 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.

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

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

*[(55)]***(57)** 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.

*[(56)]***(58)** 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*[(19)]***(21)**. Other providers include**,** but are not limited to:

(A) Audiologist (AUD or PhD);

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

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

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

(E) Chiropractor;

(F) Licensed Clinical Social Worker;

(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.

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

*[(58)]***(60)** 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.

*[(59)]***(61)** 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.

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

*[(61)]***(63)** 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.

*[(62)]***(64)** 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.

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

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

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

*[(66)]***(68)** 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.

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

*[(68)]***(70)** 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)]***(71)** Terminated vested subscriber. A previous active employee eligible for a future retirement benefit through a public entity's retirement system.

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

*[(71)]***(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.

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

*[(73)]***(75)** Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits through a public entity's retirement system.

*[(74)]***(76)** 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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (4), (5), (6), (7), (8), (9), and (10).

PURPOSE: This amendment clarifies eligibility requirements and enrollment procedures for active employees, retirees, survivors, terminated vested coverage, long-term disability, and dependent coverage; clarifies effective date provisions; clarifies proof of eligibility requirements; clarifies military leave coverage; clarifies termination requirements; clarifies voluntary cancellation of coverage requirements; clarifies continuance of coverage requirements; and clarifies Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage requirements.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(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.]***4.** If an active employee has *[elected coverage]* **been enrolled** 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.]***5.** 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]* **his/her spouse/child(ren)**, provided the employee and *[any dependents]* **his/her spouse/child(ren)** have been continuously covered for health care benefits—

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

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

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of *[dependents]* **persons** 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.]***3.** If a retiree *[or his/her dependents]* who *[are]* **is** eligible for coverage elect**s** not to be continuously covered **for him/herself and his/her spouse/child(ren)** with MCHCP from the date first eligible, or do**es** not apply for coverage **for him/herself and his/her spouse/child(ren)** within thirty-one (31) days of *[their]* **his/her** eligibility date, the*[y]* **retiree and his/her spouse/child(ren)** shall not thereafter be eligible for coverage **unless specified elsewhere herein**.

(C) Survivor Coverage.

1. At the time of *[the]* **a vested active employee** subscriber's death, *[a]* **his/her** survivor**(s)** *[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]* **to** continue coverage if the survivor**(s)** *[and his/her dependents]* had **MCHCP** coverage*[—]* **at the time of the subscriber's death. The deceased subscriber's spouse/children who do not have MCHCP coverage at the time of the death may elect MCHCP coverage and become a survivor if the spouse/child(ren) 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. T]***t**hrough group or individual medical coverage for the six (6) months immediately prior to **the** subscriber's death. **In that case,** *[P]***p**roof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of *[dependents]* **persons** covered) is required.

2. A**t the time of a retiree or terminated vested subscriber's death, his/her** survivor**(s)** *[of a retiree or terminated vested subscriber]* may **elect to** continue coverage if the survivor**(s)** had MCHCP coverage *[as a dependent]* at the time of the subscriber's death.

3. If a survivor **subsequently marries and elects to** add*[s]* **his/her** *[a]* new spouse to his/her coverage and the survivor *[subsequently]* dies, the new spouse**'s** *[is no longer eligible for]* coverage **ends at midnight on the last day of the month of the survivor's death (e.g. If the survivor dies November 3, new spouse's last day of coverage is November 30). Unless otherwise specified in this rule, the new spouse is not eligible to enroll for coverage at the time of the survivor's death**.

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.]* **If there are multiple survivors, once enrolled, the spouse will become the subscriber or, if there are only children, the youngest enrolled child will become the subscriber.**

(D) Terminated Vested Coverage.

1. An **active** employee may *[participate]* **enroll him/herself and his/her spouse/child(ren)** 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]* **spouse/child(ren)** 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]* **persons** 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 **for him/herself and his/her dependents** 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]* **spouse/child(ren)** may elect or continue coverage if the employee with long-term disability coverage and his/her *[dependents]* **spouse/child(ren)** 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]* **persons** 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.

(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 **when paternity by the dependent is established after birth** 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 or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. The public entity must enroll or waive coverage for a new employee by submitting a form signed by the employee and the payroll representative within thirty-one (31) days of his/her eligibility date. A new employee's coverage begins on the first day of the month after the hire date and the applicable waiting period.

2. An active employee may elect**, change, or cancel** coverage *[and/or change coverage levels]* **for the next plan year** during the annual open enrollment period.

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

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

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

B. Employer-sponsored group coverage loss. An employee and his/her *[dependents]* **spouse/child(ren)** 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]* **spouse/child(ren)** loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

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

E. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains **obvious** errors, MCHCP will notify the public entity**'s** Human Resource Department of such by mail, phone, or secure message. The corrected form must be submitted to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If an active employee is *[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 plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the employee and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(B) Retiree Coverage.

1. To enroll or continue coverage **for him/herself and his/her dependents** at retirement, the employee *[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 **of retirement date** with proof of prior medical, **dental, or vision** coverage under a separate group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he *[and*

his/her dependents] chooses to enroll in an MCHCP plan at retirement and ha*[ve]*s had insurance coverage for six (6) months immediately prior to his/her retirement.

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

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

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

B. Employer-sponsored group coverage loss. A retiree may enroll his/her *[dependent]* **spouse/child(ren)** within sixty (60) days if the *[dependent]* **spouse/child(ren)** 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 **him/herself and his/her spouse/child(ren)** within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

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

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

6. If a retiree is *[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 plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the retiree and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(C) Terminated Vested Coverage.

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

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

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

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her *[dependent(s)]* **spouse/child(ren)** within sixty (60) days if the *[dependent(s)]* **spouse/child(ren)** 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]* **spouse/child(ren)**. If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

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

4. If a terminated vested subscriber is *[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 plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(D) Long-Term Disability Coverage.

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

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

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

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her *[dependent(s)]* **spouse/child(ren)** within sixty (60) days if the *[dependent(s)]* **spouse/child(ren)** 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]* **spouse/child(ren)**. If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

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

4. If a long-term disability subscriber is *[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 plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the long-term disability subscriber and his/her dependents

will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(E) Survivor Coverage.

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

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

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

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

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

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

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

B. Employer-sponsored group coverage loss. A survivor may enroll his/her *[dependent(s)]* **spouse/child(ren)** within sixty (60) days if the *[dependent(s)]* **spouse/child(ren)** 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]* **spouse/child(ren)**. If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

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

5. If a survivor is *[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 plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the survivor and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(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. A new employee and his/her eligible dependents or an employee rehired after his/her coverage terminates and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date as determined by the employer. Except at initial employment, 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**, unless enrollment is received on the first day of a month, in which case coverage is effective on that day**;

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]* **newborn** of a dependent at a later date;

C. Child where paternity is established after birth. If a subscriber enrolls a child within thirty-one (31) days of the date paternity is established, 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;

*[C.]***D.** 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.]***E.** 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.]***F.** 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.]***G.** Employee.

(I) If an employee enrolls due to a life event **or loss of employer-sponsored coverage**, 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 **or spouse/child(ren)** will be terminated or will not take effect.

(B) An employee and/or his/her *[dependents]* **spouse/child(ren)** enrolling due to a loss of other coverage. The employee must submit documentation of proof of loss to MCHCP through his/her public

entity**'s** Human Resource Department within sixty (60) days of enrollment.

(C) A retiree, survivor, terminated vested subscriber, or long-term disability subscriber enrolling *[dependents]* **his/her spouse/child(ren)** 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]* **spouse/child(ren)** within sixty (60) days of enrollment.

(D) Documentation is also required when a subscriber attempts to terminate a *[dependent's]* **spouse's/child'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]* **spouse's/child's** name, birth date, eligibility date, and Social Security number.

(F) Disabled dependent.

1. A new employee may enroll his/her permanently disabled *[dependent]* **child** or a**n** *[currently]* enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the 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]* **child**:

A. Evidence that the permanently disabled dependent was entitled to and receiving disability benefits prior to turning age twenty-six (26) years. 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]* **child's** physician describing the current disability and verifying that the disability predates the *[dependent's]* **child'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]* **child** is still considered disabled by SSA.

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

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

(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 **or if the employee was on military leave during open enrollment or while on military leave had a qualifying life event, the employee may change plans and add his/her spouse/child(ren)**. 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 **enrolled ex-**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 or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

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*[.]***; or**

8. A member otherwise loses benefit eligibility.

(8) Voluntary Cancellation of Coverage.

(C) A subscriber cannot cancel medical coverage on his/her *[spouse or children]* **dependents** 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*[.]***; or**

4. When new coverage is taken through other employment.

(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'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.

4. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage 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 **or if the employee was on leave of absence during open enrollment or while on leave of absence had a qualifying life event or loss of employer-sponsored coverage, the employee may change plans and add spouse/child(ren)**. For coverage to be reinstated, the employee must submit a completed Enroll/Change/Cancel/Waive form within thirty-one (31) days of returning to work. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date.

5. If the employee chooses to maintain employee coverage but not coverage for his/her *[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]* **taking the** leave of absence. **If the employee was on FMLA leave during MCHCP's annual open enrollment, or if while the employee was on FMLA leave, the employee had a qualifying life event or loss of employer-sponsored coverage, the employee may change plans and add his/her spouse/child(ren) within thirty-one (31) days of returning to work.**

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]* **spouse/child(ren)** 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]* **spouse/child(ren)** 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]* dependent*[s]* who *[have]* **has** 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 **enrolled** spouse and *[dependents]* **stepchild(ren)** 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 and the disability continues during the rest of the initial eighteen- (18-) month period of continuation of coverage, the member may continue coverage for up to an additional eleven (11) months.

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

(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.

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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment clarifies requirements for prior authorization of services, including: procedure codes ending in "T", bariatric surgery, and medications; adds a prior authorization requirement for hearing aids; clarifies retrospective review; and adds language regarding pre-determination of coverage and case management.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(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]* **denied for payment**. Members who have another primary carrier, including Medicare, are not subject to this provision **except for those services that are not covered by the other primary carrier, but are otherwise subject to prior authorization under this rule**. Prior authorization does not verify eligibility or payment. Prior authorizations *[based on]* **found to have** a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition *[will not]* **may** be *[covered]* **rescinded**;

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) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service;

D. Auditory brainstem implant (ABI);

E. Bariatric *[procedures]* **surgery**;

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. Hearing aids

*[M.]***N.** Home health care;

*[N.]***O.** Hospice care and palliative services;

*[O.]***P.** Hospital inpatient services *[except for observation stays]*;

*[P.]***Q.** 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;

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

*[R.]***S.** Nutritional counseling after *[three (3)]* **six (6)** sessions annually;

*[S.]***T.** Orthognathic surgery;

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

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

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

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

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

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

*[Z.]***AA.** 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

*[AA.]***BB.** 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. Medication with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy **or the mail order** 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*[.]* **at retail or the mail order pharmacy; and**

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 ninety (90) 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;

(C) Retrospective Review—Reviews *[conducted]* **to determine coverage** after services have been provided to a patient. The retrospective review *[does not include the review of a claim that]* is **not** limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation, *[or]* coding, or settling of payment. **The claim administrator shall have the authority to correct payment errors when identified under retrospective review.**

(D) Pre-determination—Determination of coverage by the claims administrator prior to services being provided. A provider may voluntarily request a pre-determination. A pre-determination informs the provider of whether, and under which circumstances, a procedure or service is generally a covered benefit under the plan. A pre-determination that a procedure or service may be covered under the plan does not guarantee payment.

(E) Case Management—A voluntary process to assess, coordinate, and evaluate options and services of members with catastrophic and complex illnesses. A case manager will help members understand what to expect during the course of treatment, help establish collaborative goals, complete assessments to determine needs, interface with providers, and negotiate care. Members are identified for case management through claim information, length of hospital stay, or by referral. The case manager will dismiss the member from case management once the case manager determines that objectives have been met.

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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), and (4).

PURPOSE: This amendment clarifies member responsibility for newborn claims; adds nutritional counseling benefit information; clarifies the mental health office visit copayment; and clarifies the plan out of pocket maximum.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(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).

(C) *[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.]* **If the mother is a Missouri Consolidated Health Care Plan (MCHCP) member, the claim(s) for the newborn's initial hospitalization will be covered at one hundred percent (100%) until discharge or transfer to another facility.**

(D) If the mother is not an MCHCP member, the claims for the newborn's initial hospitalization will be subject to his/her own deductible and coinsurance.

(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.

(E) Preventive care—Network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible **is met**. Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.

(F) Nutritional counseling—Network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after deductible is met.

(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.

(A) Office visit—Office visit—primary care: twenty-five dollars ($25)**; mental health: twenty-five dollars ($25)**; specialist: forty dollars ($40); chiropractor office visit and/or manipulation: twenty dollars ($20); urgent care: fifty dollars ($50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

1. Vision office visit or refraction—forty dollars ($40).

2. Hearing test—performed by a primary care physician: twenty-five dollars ($25); performed by a specialist: forty dollars ($40).

(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.*

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

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

*[(C)]***(B)** Network out-of-pocket maximum for individual—four thousand five hundred dollars ($4,500).

*[(D)]***(C)** Network out-of-pocket maximum for family—*[twelve thousand five hundred dollars ($12,500)]* **nine thousand ($9,000)**.

*[(E)]***(D)** Non-network out-of-pocket maximum for individual—ten thousand dollars ($10,000).

*[(F)]***(E)** Non-network out-of-pocket maximum for family—thirty thousand dollars ($30,000).

*[(G)]***(F)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged **include, but are not limited to**: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum 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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.055 *[High Deductible]* **Health** ***Savings Account*** **Plan Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is amending the title, purpose, and sections (1), (2), (3), and (8).

PURPOSE: This amendment revises the title, purpose, and section (8) to reflect the High Deductible Health Plan name change; clarifies member responsibility for newborn claims; adds nutritional counseling benefit information; clarifies that medical and pharmacy expenses contribute to the plan out of pocket maximum; and clarifies Health Savings Account Plan eligibility.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the [High Deductible] ***Health Savings Account (HSA) Plan, 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, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(1) Deductible amount—Network: per individual each calendar year, one thousand six hundred fifty dollars ($1,650); family each calendar year, three thousand three hundred dollars ($3,300). Non-network: per individual each calendar year, four thousand dollars ($4,000); family each calendar year, eight thousand dollars ($8,000).

(C) *[If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the n]***N**ewborn's claims will be subject to deductible and coinsurance *[during the hospital admission]*.

(D) Medical and pharmacy expenses are combined to apply toward the network or non-network deductible amount, as appropriate.

(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.

(E) Preventive care—Network claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible **is met**. Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.

(F) Nutritional Counseling—Network claims are paid at one hundred percent (100%) after deductible is met. Non-network claims are paid at sixty percent (60%) coinsurance after deductible is met.

(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.*

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

*[(B)]***(A)** The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member.

*[(C)]***(B)** Network out-of-pocket maximum for individual—three thousand three hundred dollars ($3,300).

*[(D)]***(C)** Network out-of-pocket maximum for family—six thousand six hundred dollars ($6,600).

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

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

*[(G)]***(F)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include**, but are not limited to**: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed *[amount for transplants performed by a non-network provider]*.

(G) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

(H) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

(8) A subscriber does not qualify for the *[High Deductible Health Plan (HDHP)]* **Health Savings Account Plan (HSA Plan)** if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (9) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(E) *[The member has veteran's benefits that have been used within the past three (3) months.]* **If the member has received medical benefits from the Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.**

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. [2013] **2014**. 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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (3); adding section (6); and renumbering as necessary.

PURPOSE: This amendment clarifies member responsibility for newborn claims; adds nutritional counseling benefit information; and adds an emergency room visit copayment.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(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).

(C) *[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]* **If the mother is a Missouri Consolidated Health Care Plan (MCHCP) member, the claim(s) for the newborn's initial hospitalization will be covered at one hundred percent (100%) until discharge or transfer to another facility.**

(D) If the mother is not an MCHCP member, the claims for the newborn's initial hospitalization will be subject to his/her own deductible and coinsurance.

(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.

(E) Preventive care—Network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible **is met**. Influenza immunizations are reimbursed up to twenty-five dollars ($25) when received out of network if the member submits a receipt and a Non-Network Flu Shot Reimbursement form.

(F) Nutritional counseling—Network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after deductible is met.

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

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

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

*[(C)]***(B)** Network out-of-pocket maximum for individual—one thousand five hundred dollars ($1,500).

*[(D)]***(C)** Network out-of-pocket maximum for family—three thousand dollars ($3,000).

*[(E)]***(D)** Non-network out-of-pocket maximum for individual—three thousand dollars ($3,000).

*[(F)]***(E)** Non-network out-of-pocket maximum for family—six thousand dollars ($6,000).

*[(G)]***(F)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include**, but are not limited to**: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed *[amount for transplants performed by a non-network provider]*.

(6) Copayments—Copayments do not apply to the deductible.

(A) Emergency room—one hundred dollars ($100) network and non-network. Deductible and coinsurance are applied in addition to the copayment. If a member is admitted to the hospital, the copayment is waived.

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

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

*[(8)]***(9)** Services received while out of the country may be covered if the service is included in 22 CSR 10-3.057 and will be subject to any prior authorization requirements provided for in 22 CSR 10-3.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (2), and (4); removing section (3); and renumbering as necessary.

PURPOSE: This amendment revises the name of the High Deductible Health Plan; removes language regarding disease management requirements; removes language regarding member responsibility for mother and newborn claims; clarifies the plans to which the benefits in this rule apply; clarifies transition of care requirements; clarifies hearing aid benefits; clarifies injections and infusion benefits; clarifies nutritional counseling benefits; and clarifies transplant expense benefits; and adds diabetic education benefits.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(1) Benefit Provisions Applicable to the *[PPO 300 Plan]*, PPO 600 Plan, **PPO 1000 Plan,** and *[High Deductible Health Plan (HDHP)]* **Health Savings Account (HSA) Plan**. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. 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 subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the *[same]* fee as paid **as allowed by any applicable secondary network agreements or the fee as paid to the provider** prior to leaving the network**, whichever is lesser**. Benefits eligible for transition of care include:

[(3) Disease Management.

(A) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in an UMR plan 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 non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in a Coventry plan 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 with one (1) other disease management condition; or

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

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

*[(4)]***(3)** Covered Charges Applicable to the *[PPO 300 Plan,]* PPO 600 Plan, **PPO 1000 Plan,** and *[HDHP]* **HSA Plan**.

(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 services:

1. Prescribed by an appropriate 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.

(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 provider visit to seek a second opinion.

(D) Services in a 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) Plan benefits for the *[PPO 300 Plan']* PPO 600 Plan, **PPO 1000 Plan,** and *[HDHP]* **HSA Plan** are as follows:

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

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

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents).

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

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents).

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

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

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

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

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

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

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

(II) Skin testing is unreliable.

H. Exercise Challenge Testing for exercise-induced bronchospasm;

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

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

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

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

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

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

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: Routine allergy re-testing is not considered medically necessary;

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

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);

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

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

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

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

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

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

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

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

C. All of the following criteria have been met:

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

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

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

I. Type II diabetes;

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

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

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

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

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

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

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

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

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only*[:]*—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

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

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

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

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

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

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

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

A. Genetic or hereditary hemochromatosis;

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

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

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

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

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

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

J. Cystinuria;

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

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

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

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

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

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

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

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

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

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

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

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

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

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

[E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;]

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

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

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

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

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

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

(I) National Institutes of Health (NIH);

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

(III) Agency for Health Care Research and Quality;

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

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

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

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

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

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that

the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

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

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

13. Diabetic Education when prescribed by a provider and taught by a Certified Diabetes Educator through a network provider.

*[13.]***14.** Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to**,** the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to**,** the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment **which** renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

*[14.]***15.** 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 the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

*[15.]***16.** 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;

*[16.]***17.** Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to**,** any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease;

(III) Peripheral neuropathy; and

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

*[17.]***18.** Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with mental retardation, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

*[18.]***19.** Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). 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;

*[19.]***20.** Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

*[20.]***21.** 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);

*[21.]***22.** 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. Prior to receiving a hearing aid members must receive—

(I) A comprehensive exam by a qualified provider which includes case history, visual inspection, pure-tone screening, and screening by self-assessment of hearing disability; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, speech-language pathologist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

*[A.]***(I)** Conventional: one thousand dollars ($1,000).

*[B.]***(II)** Programmable: two thousand dollars ($2,000).

*[C.]***(III)** Digital: two thousand five hundred dollars ($2,500).

*[D.]***(IV)** Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500).

*[22.]***23.** Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

*[23.]***24.** Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by a provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in

a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

*[24.]***25.** Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

*[25.]***26.** Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services 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; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

*[26.]***27.** Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition *[or]* **of** alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastamosis status;

(XXI) Acquired absence of stomach; *[and]*

(XXII) Pancreatic insufficiency; and

*[(XXII)]***(XXIII)** Ideopathic progressive polyneuropathy;

*[27.]***28.** Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered.

*[28.]***29.** Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after 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. Newborns covered by the PPO 600 or PPO 1000 plan will be subject to deductible and coinsurance if mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance;]*

*[29.]***30.** 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 ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services 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;]* **is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian).**

*[30.]***31.** Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings; and

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

*[31.]***32.** Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

*[32.]***33.** Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes**,** but is not limited to**,** reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

*[33.]***34.** Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

*[34.]***35.** Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions;

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with a goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom*[.]***;**

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an intergral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis; and

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions (such as metatarsus adductus, tibial torsion, or femoral torsion).

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

*[35.]***36.** 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 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. Zoster vaccination (shingles)—The zoster vaccine is covered for members age of fifty (50) years and older;

*[36.]***37.** Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

*[37.]***38.** Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis),

or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

*[38.]***39.** Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

*[39.]***40.** Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.

*[40.]***41.** Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person.

*[41.]***42.** Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver-provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, postoperative vocal cord surgery);

*[42.]***43.** Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. **The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined** *[T]***travel and lodging expenses are** *[is]* limited to *[a]* ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered. Non-network facility charges and payments for transplants are limited to the following maximums:

(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);

*[43.]***44.** Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

*[44.]***45.** Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is removing section (1); amending sections (4), (5), and (6); and renumbering as necessary.

PURPOSE: This amendment adds facsimile numbers for appeal submissions for both UMR and Coventry Health Care of Kansas, Inc.; clarifies the Coventry Health Care of Kansas, Inc.'s plan name; clarifies Express Script's appeals address; adds language regarding the Pharmacy Lock-In Program; adds facsimile and website information for appeals sent to the Missouri Consolidated Health Care Plan Board of Trustees; revises the name of the High Deductible Health Plan; clarifies that payment in full must be included with the appeal; and clarifies the timeframe for submitting an appeal to enroll due to late notification of loss of coverage.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

[(1) General Provision. The board of trustees has the right to suspend, revise, or remove eligibility and benefit requirements in the case of a disaster or emergency situation.]

*[(2)]***(1)** Claims Submissions and Initial Benefit Determinations.

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied**,** or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible**,** thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend

the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen- (15-) day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied**,** or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, *[or]* a provider, or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the timeframes described in this rule that will include the following information:

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based, with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

*[(3)]***(2)** General Appeal Provisions.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave rise to the appeal.

*[(4)]***(3)** 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. 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 **of Kansas, Inc.**, 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; and

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.

(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 by someone 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 by someone 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 by someone 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 Appeals
PO Box 400046
San Antonio, TX 78229
or by fax to (888) 615-6584

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546
or by fax to (877) 291-3248

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care **of Kansas, Inc.**—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care **of Kansas, Inc.**
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
or by fax to (866) 769-2408

(b) Expedited appeals must be communicated by calling (913) 202-5000 or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy **and the Pharmacy Lock-In Program** consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals**. Pharmacy appeals and Pharmacy Lock-In Program appeals** must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, **and any applicable reason(s) relevant to the appeal including:** the reason**(s)** the member believes the claim should be paid, **the reason(s) the member believes s/he should not be included in the Pharmacy Lock-In Program,** and any other written documentation to support the 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 BL0390
6625 W. 78th St.
Bloomington, MN 55439]
Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63116-6588
or by fax to (877) 852-4070

(III) All Pharmacy Lock-In Program appeals must be submitted in writing to—

Express Scripts
Drug Utilization Review Program
100 Parsons Pond Dr.
Franklin Lakes, NJ 07417-2603

*[(III)]***(IV)** 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.

(V) The Pharmacy Benefit Manager will respond to Pharmacy Lock-In Program appeals in writing to the member within thirty (30) days from the date the Pharmacy Benefit Manager 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—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number (888) 866-6205 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 timeframe 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.

*[(5)]***(4)** Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by *[fax or letter to the following address]* **sending or uploading the written appeal to one of the following**:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110
or by fax to (866) 346-8785
or online at www.mchcp.org

*[(6)]***(5)** In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn retroactively to the date of birth if the *[initial request is made in writing to the board of trustees]* **appeal is received** within three (3) months of the child's birth date. Valid proof of eligibility must be included with the appeal *[for the request to be considered]*;

(B) MCHCP may approve a subscriber's appeal and not hold the subscriber responsible when there is credible evidence that there has been an error or miscommunication through the subscriber's payroll/personnel office, MCHCP, or MCHCP vendor that was no fault of the subscriber;

(C) MCHCP may approve an appeal to change the type of medical or vision plan that the subscriber elected **or defaulted to** during the annual open enrollment period if the request is made 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]* **Health Savings Account (HSA) Plan** elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. This guideline may not be used to elect or cancel coverage or to enroll or cancel dependents. 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 cafeteria plan;

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account. *[The subscriber must include p]***P**ayment in full for all past and current premiums due for reinstatement **must be included with the appeal**;

(E) MCHCP may approve a subscriber's appeal to terminate dental and/or vision coverage if the appeal is received within thirty-one (31) calendar days of the beginning of the new plan year and if no claims have been made or paid during the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by a cafeteria plan;

(F) MCHCP may approve an appeal regarding late receipt of proof-of-eligibility documentation if the subscriber can provide substantiating evidence that it took an unreasonable amount of time for the government agency creating the documentation to provide subscriber with requested documentation;

(G) MCHCP may approve a subscriber's appeal to enroll after a deadline due to late notice of loss of coverage from subscriber's previous carrier if the appeal is *[timely]* **within sixty (60) days** from date of late notice;

(H) 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;

(I) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are 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 cafeteria plan;

(J) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated; and

(K) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.

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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending the purpose and sections (1), (2), and (5); removing sections (3), (6), (9), and (10); and renumbering as necessary.

PURPOSE: This amendment revises the name of the High Deductible Health Plan; adds language regarding the specialty split-fill program; clarifies language regarding coverage of compounds; clarifies language regarding drugs covered at one hundred percent (l00%); removes language regarding formulary contraception; clarifies language regarding prescriptions filled at a non-network facility; clarifies the prescription out-of-pocket maximum; clarifies the step therapy program; removes language regarding the Disease Management Program; removes language regarding grandfathered specialty drugs; removes language regarding guidelines for drug use; and removes language regarding the Affordable Care Act required zero dollar drugs.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, [PPO 2000 Plan, and HDHP with HSA] ***Health Savings Account (HSA) Plan*** *of the Missouri Consolidated Health Care Plan.*

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a *[physician]* **provider**.

(A) PPO 600 and PPO 1000 Prescription Drug Coverage.

1. Network.

A. Generic copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Home delivery program—

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic copayments: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary.

(b) Brand copayments: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty-cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d) A member must choose how maintenance prescription(s) will be filled by notifying the pharmacy benefit manager (PBM) of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(e) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision **and the amount charged will not apply to the out-of-pocket maximum**.

(f) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply **unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply**. The first specialty prescription order may be filled through a retail pharmacy **except for those select drugs that have been included in the specialty split-fill program**.

(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) for a drug not on the formulary; *[and]*

(III) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment.

Starting with the fourth month, and up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

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. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. **If any ingredient in the compound is excluded by the plan, the compound will be denied.**

G. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

H. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug **which shall not apply to the out-of-pocket maximum**.

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) **and, for women, by the Health Resources and Services Administration** are covered at one hundred percent (100%) **when filled at a network pharmacy**. The following are also covered at one hundred percent (100%) **when filled at a network pharmacy**:

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

[(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.]

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

2. Non-network: If a member chooses to use a non-network pharmacy **for non-specialty prescriptions**, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable **network** copayment.

[A. Generic copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply for a drug not on the formulary.]

3. Out-of-pocket maximum. *[The out-of-pocket maximum is the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.]*

A. Network and non-network out-of-pocket maximums are *[not]* separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—*[six thousand two hundred fifty dollars ($6,250)]* **five thousand one hundred dollars ($5,100)**.

D. Family—*[twelve thousand five hundred dollars ($12,500)]* **ten thousand two hundred dollars ($10,200)**.

(B) *[High Deductible Health Plan (HDHP) with]* Health Savings Account *(HSA)* **Plan** Prescription Drug Coverage. **Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.**

1. Network.

A. Generic: Ten percent (10%) 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: Forty percent (40%) 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.

(a) Generic: Ten percent (10%) coinsurance after deductible **has been met** for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible **has been met** for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible **has been met** for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(e) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(f) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs **are** covered only through network home delivery for up to thirty-one*[-]* (31*[-]*) days.

(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary*[; and]***.**

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) **and, for women, by the Health Resources and Services Administration** are covered at one hundred percent (100%) **when filled at a network pharmacy**. The following are also covered at one hundred percent (100%) **when filled at a network pharmacy**:

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

[(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines

a generic is not medically appropriate or a generic version is not available].

(IV) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer.

F. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the pharmacy benefit manager, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

(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-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-step drug, the physician may request a prior authorization from the PBM. If the prior authorization is approved, the member is responsible for the applicable copayment, which may be higher than the 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-step drugs must be *[used]* **attempted** before the plan will authorize payment for second-step drugs.

[(3) Disease Management (DM) Program Reduced Non-Formulary Prescription Copayments—

(A) Members who are actively participating in the DM Program and enrolled in the PPO 600 Plan or PPO 1000 Plan are eligible for a reduced non-formulary prescription copayment as follows:

1. Fifty-five dollars ($55) for up to a thirty-one- (31-) 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 DM Program when s/he is enrolled in a DM Program through the medical plan vendor and one (1) of the following:

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 medical plan vendor determines the condition can be managed independently; or

3. The medical plan vendor has determined the member does not require one-on-one work with a DM nurse.

(C) A member is no longer eligible for reduced non-formulary prescription copayment when the medical plan vendor determines s/he is no longer actively participating in the DM program.]

*[(4)]***(3)** Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. A member may request a claim form from the plan or the PBM. In order to file a claim, the member must—

(A) Complete the claim form;

(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) A member 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 amount as determined by the PBM, less any applicable copayment, deductible, or coinsurance. A member is responsible for any charge over the network discounted price and the applicable copayment.

*[(5)]***(4)** Formulary*[.]***—**The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies;

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit **unless otherwise specified**; or

(C) A drug is determined to have a safety issue by the United States Food and Drug Administration (FDA). If this occurs, then the drug is no longer covered under the pharmacy benefit.

[(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. 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 hypertension drugs; and

(P) Somatostatin analogs.]

*[(7)]***(5)** 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.

*[(8)]***(6)** Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the FDA or credible scientific evidence published in peer-reviewed medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

[(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.

(10) Affordable Care Act (ACA) required zero dollar drugs. The following drugs are covered at one hundred percent (100%) coverage:

(A) Prescribed over-the-counter nicotine replacement;

(B) Non-formulary brand contraceptive when the individual's health care provider determines that the covered generic would be medically inappropriate for that individual; and

(C) Non-formulary brand contraceptive when a generic version does not exist for one (1) of the FDA-approved contraceptive methods such as barrier, hormonal, or implanted devices.]

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. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.150 Disease Management Services Provisions and Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regards to the disease management services including the disease management program, the disease management incentive, and the diabetes management incentive; and the method and timeframes in which the requirements of the incentive must be completed.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2015, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 29, 2014, becomes effective January 1, 2015, and expires June 29, 2015.*

(1) Disease management services include: disease management, disease management incentive, and the diabetes management incentive. Disease management is administered through MCHCP's disease management vendor. The disease management incentive and the diabetes management incentive are administered through the MCHCP Pharmacy Benefit Manager in conjunction with Missouri Consolidated Health Care Plan's (MCHCP) disease management vendor. Participation in any of the disease management services is voluntary. Eligible members are responsible for enrolling, participating, and completing requirements by the applicable deadlines outlined in this rule.

(2) Disease Management.

(A) Eligibility—The following members enrolled in a MCHCP Preferred Provider Organization (PPO) or Health Savings Account (HSA) Plan are eligible to participate in disease management (DM):

1. Non-Medicare subscribers; and

2. Non-Medicare dependents of DM eligible subscribers.

(B) Limitations and Exclusions—The following members are not eligible to participate in DM:

1. Subscribers with Medicare primary coverage;

2. Dependents with Medicare primary coverage;

3. TRICARE Supplement Plan subscribers;

4. Dependents of DM ineligible subscribers;

5. When Medicare becomes a DM eligible subscriber's primary insurance payer, the subscriber and DM eligible dependent(s) are no longer eligible to participate and will lose the incentives the first day of the month in which Medicare becomes primary; and

6.When Medicare becomes a DM eligible dependent's primary insurance payer, the DM eligible dependent is no longer eligible to participate and will lose the incentives the first day of the month in which Medicare becomes primary.

(C) An eligible member may participate in a DM program appropriate for managing a chronic condition if s/he meets the relevant age criterion and has one (1) or more of the following chronic conditions:

1. Asthma—open to those aged six (6) and over;

2. Cancer—open to those aged eighteen (18) and over;

3. Chronic obstructive pulmonary disease—open to those aged eighteen (18) and over;

4. Congestive heart failure—open to those aged eighteen (18) and over;

5. Coronary artery disease—open to those aged eighteen (18) and over;

6. Depression—open to those aged eighteen (18) and over;

7. Diabetes—open to those aged six (6) and over;

8. Musculoskeletal/chronic pain (including low back pain)—open to those aged 18 and over;

9. Obesity (Body Mass Index $\geq$ 30)—open to those aged 18 and over; or

10. Hypertension as a co-morbid condition to any of the chronic conditions listed herein—open to those aged 18 and over.

(D) A member identified as eligible for DM through medical and prescription drug claims evaluated by MCHCP's DM vendor will receive an invitation to participate in DM from the DM vendor.

(E) A member can self-identify to the DM vendor with a provider's written statement that includes the member's diagnosis of a DM-eligible chronic condition.

(F) For the purposes of this rule, a member is considered actively participating in DM when s/he is enrolled in a DM program through MCHCP's DM vendor and one (1) of the following occurs:

1. Is working one-on-one with a DM nurse;

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a DM nurse until the DM vendor determines the condition can be managed independently; or

3. The DM vendor has determined the member does not require one-on-one work with a DM nurse.

(3) Disease Management Incentive.

(A) Members actively participating in DM are eligible to receive the respective reduced non-formulary prescription copayment or coinsurance:

1. PPO 600 Plan or PPO 1000 Plan members—

A. Fifty-five dollars ($55) copayment for up to a thirty-one- (31-) day supply at a network retail pharmacy;

B. One hundred ten dollars ($110) copayment for up to a sixty- (60-) day supply at a network retail pharmacy;

C. One hundred sixty-five dollars ($165) copayment for up to a ninety- (90-) day supply at a network retail pharmacy;

D. One hundred thirty-seven dollars and fifty cents ($137.50) copayment for up to a ninety- (90-) day supply filled through the home delivery program;

2. HSA Plan members—

A. Thirty percent (30%) coinsurance after deductible has been met at a network pharmacy.

(B) Members actively participating in DM on December 1, 2014 will receive the DM Incentive through January 31, 2015 to allow the member to enroll and begin active participation in the 2015 DM program.

(4) The incentives will start no later than thirty (30) days after active participation begins.

(5) Eligible members failing to actively participate in DM will lose the disease management incentive or the diabetes management incentive and will become ineligible for the respective incentive(s) for the remainder of the year.

(6) Audit—MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from DM, loss of the disease management incentive and the diabetes management incentive, and/or prosecution.

(7) Coordination of programs—MCHCP and its DM vendor may utilize participation data for purposes of offering additional programs in accordance with MCHCP's privacy policy.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 29, 2014, effective Jan. 1, 2015, expires June 29, 2015. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 2—Health Requirements for Movement of Livestock, Poultry, and Exotic Animals

PROPOSED AMENDMENT

2 CSR 30-2.010 Health Requirements Governing the Admission of Livestock, Poultry, and Exotic Animals Entering Missouri. The director is amending subsection (4)(D).

PURPOSE: This amendment exempts bison from Trichomoniasis testing requirements, clarifies laboratories acceptable for testing, and removes the restriction on bulls that have tested positive for Trichomoniasis to enter Missouri.

(4) Cattle (beef and dairy), Bison, and Exotic Bovids. All cattle, bison, or exotic bovids exchanged, bartered, gifted, leased, or sold entering Missouri must meet the following requirements:

(D) Trichomoniasis Requirements.

1. All breeding bulls (excluding **bison and** exotic bovids) entering the state shall be—

A. Virgin bulls not more than twenty-four (24) months of age as determined by the presence of both permanent central incisor teeth in wear or by breed registry papers; or

B. Be tested negative for Trichomoniasis with an official culture test or official Polymerase Chain Reaction (PCR) test by an *[approved diagnostic]* **official** laboratory within thirty (30) days prior to entry into the state.

(I) Bulls shall be tested three (3) times not less than one (1) week apart by an official culture test or one (1) time by official PCR test prior to entering Missouri.

(II) Bulls shall be identified by official identification at the time the initial test sample is collected.

(III) Bulls that have had contact with female cattle subsequent to testing must be retested prior to entry.

2. If the breeding bulls are virgin bulls, less than twenty-four (24) months of age, they shall be—

A. Individually identified by official identification;

B. Be accompanied with a breeder's certification of virgin status signed by the breeder or his representative attesting that they are virgin bulls; and

C. The official identification number shall be written on the breeder's certificate.

3. A Certificate of Veterinary Inspection listing official identification and test performed, date of test, results, and laboratory, if testing is required.

4. *[Any bull which has ever tested positive for Trichomoniasis will not be allowed to enter Missouri.]* **Bulls going directly to slaughter are exempt from Trichomoniasis testing.**

[5. Bulls going directly to slaughter are exempt from Trichomoniasis testing.]

AUTHORITY: section 267.645, RSMo 2000. This version of rule filed Jan. 24, 1975, effective Feb. 3, 1975. Amended: Filed Aug. 15, 1975, effective Aug. 25, 1975. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Oct. 30, 2014.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment does not add additional cost to the producer to import an animal into Missouri. The existing cost of compliance to import an animal into Missouri is an estimated fifty dollars ($50) to eighty-five dollars ($85) per animal.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, Linda Hickam, DVM, State Veterinarian, PO Box 630, Jefferson City, MO 65102 or by email to linda.hickam@mda.mo.gov. To be considered comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name	**2 CSR 30-2-010** **Health Requirements Governing the Admission of Livestock, Poultry, and Exotic Animals Entering Missouri**
Type of Rulemaking	**Proposed**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
117+	livestock producers	$50 - $85 per animal

III. Worksheet

$50 - $85 per animal

IV. Assumptions

The proposed amendment does not add additional cost to the producer to import a bull into Missouri.

To meet the existing requirements for bulls entering Missouri, the producer is required to have the animal(s) tested prior to entering Missouri. The estimated charge would include (but not limited to): sample collection fee, a trip fee that would vary on the distance from the veterinary clinic to the farm, sample shipping charge to laboratory for testing, laboratory test charges, and a charge to complete a Certificate of Veterinary Inspection.

Title 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 2—Health Requirements for Movement of Livestock, Poultry, and Exotic Animals

PROPOSED AMENDMENT

2 CSR 30-2.020 Movement of Livestock, Poultry, and Exotic Animals Within Missouri. The director is amending subsection (1)(D).

PURPOSE: This amendment exempts bison from Trichomoniasis testing requirements, clarifies laboratories acceptable for testing, changes the testing time frame for change of ownership or possession within the state of Missouri, and adds a provision for epidemiological investigations to be conducted on infected herds and reclassification request of a positive animal.

(1) Cattle, Bison, and Exotic Bovids.

(D) Trichomoniasis (Excluding **Bison and** Exotic Bovids).

1. Definitions.

A. Official laboratory—**A** Veterinary Diagnostic Laboratory operated **by** and under the direction of the state veterinarian, **the** University of Missouri Veterinary Medical Diagnostic Laboratory, or other diagnostic laboratories *[approved by the state veterinarian]* **accredited by the American Association of Veterinary Laboratory Diagnosticians or member of the National Animal Health Laboratory Network**.

B. Positive Trichomoniasis (*Tritrichomonas foetus*) bull—male bovine which has ever tested positive for Trichomoniasis (*Tritrichomonas foetus*).

C. Trichomoniasis—**a** venereal disease of cattle caused by the protozoan parasite species of *Tritrichomonas foetus*.

D. Positive Trichomoniasis (*Tritrichomonas foetus*) herd—**a** group of bovines that have commingled in the previous breeding season and in which an animal (male or female) has had a positive diagnosis for *Tritrichomonas foetus*.

E. Negative Trichomoniasis (*Tritrichomonas foetus*) herd—a group of bovines that have been commingled in the previous breeding season and all test-eligible bulls have tested negative for *Tritrichomonas foetus* within the previous twelve (12) months.

F. Test-eligible animal—any bull at least twenty-four (24) months of age or any non-virgin bull that is sold, leased, bartered, or traded in Missouri.

G. Negative Trichomoniasis (*Tritrichomonas foetus*) bull—a bull *[from a negative Trichomoniasis herd]* with a series of three (3) negative cultures at least one (1) week apart or one (1) negative Polymerase Chain Reaction (PCR) test for *Tritrichomonas foetus* or two (2) negative PCR **tests** if commingled with a positive **Trichomoniasis** herd.

2. All breeding bulls (excluding **bison and** exotic bovids) sold, bartered, leased, or traded within the state shall be—

A. Virgin bulls not more than twenty-four (24) months of age as determined by the presence of both permanent central incisor teeth in wear, or by breed registry papers; or

B. Tested negative for Trichomoniasis with an official culture test or official Polymerase Chain Reaction (PCR) test by an approved diagnostic laboratory within *[thirty (30)]* **sixty (60)** days prior to change in ownership or possession within the state.

(I) Bulls shall be tested three (3) times not less than one (1) week apart by an official culture test or one (1) time by an official PCR test.

(II) Shall be identified by official identification at the time the initial test sample is collected and the official identification recorded on the test documents.

(III) Bulls that have had contact with female cattle subsequent to or at the time of testing must be retested prior to movement.

C. The official identification, test results, date of test, test performed, and laboratory where test was performed *[should]* **must** be included on the certificate of veterinary inspection.

3. If the breeding bulls are virgin bulls and less than twenty-four (24) months of age, they shall be—

A. Individually identified by official identification; and

B. Accompanied with a breeder's certification of virgin status signed by the breeder or his representative attesting that they are virgin bulls.

C. The official identification number shall be written on the breeder's certificate.

4. Bulls going directly to slaughter are exempt from Trichomoniasis testing.

5. *Tritrichomonas foetus* positive herd—

A. Shall be quarantined or sold directly to slaughter or to a licensed livestock market for slaughter only and shipped on a VS 1-27 permit.

(I) Any non-virgin female or female twelve (12) months of age or older may be sold directly to slaughter and move on a VS 1-27 permit or remain quarantined.

(II) Positive bulls shall be sent directly to slaughter or to a licensed livestock market for slaughter only and shipped on a VS 1-27 permit.

(III) Positive animals shall be identified by a state issued temper-evident eartag; *[and]*

B. The quarantine shall be released upon the following:

(I) All bulls in a positive *Tritrichomonas foetus* herd shall have tested negative to three (3) consecutive official *Tritrichomonas foetus* culture tests or two (2) consecutive official *Tritrichomonas foetus* PCR tests at least one (1) week apart. The initial negative test is included in the series of negative tests required; and

(II) Female(s) has a calf at side (with no exposure to other than known negative *Tritrichomonas foetus* bulls since parturition), has one hundred twenty (120) days of sexual isolation, or is determined by an accredited veterinarian to be at least one hundred twenty (120) days pregnant*[.]***;**

C. An epidemiological investigation shall be performed on each infected herd.

(I) The Missouri Department of Agriculture shall notify adjacent herd owners that their herd may have been exposed to Trichomoniasis.

(II) The Missouri Department of Agriculture shall educate adjacent herd owners about Trichomoniasis, including a recommendation that adjacent herd owners have their herds tested for the disease.

(III) The Missouri Department of Agriculture may require the adjacent herd owner to test the adjacent herd for Trichomoniasis if it is indicated by the epidemiological investigation;

D. A request for reclassification of a positive bull shall be considered by the state veterinarian providing the owner or agent submits a written request to the state veterinarian within ten (10) business days of the initial positive test result being reported to the owner agent;

E. Upon receipt of a request for reclassification the state veterinarian shall conduct an investigation that shall include, but is not limited to, further analysis of the original positive sample, additional testing of the positive bull, and/or review of the herd record data for the bull in question. The owner or agent must pay the expenses for all tests conducted by or requested by the state veterinarian on the owner's herd; and

F. The state veterinarian shall send a written response to the owner or agent stating why the reclassification was or was not granted within ten (10) business days after the investigation is completed.

6. All positive *Tritrichomonas foetus* test results must be reported to the state veterinarian within seventy-two (72) hours of confirmation.

AUTHORITY: section 267.645, RSMo 2000. Original rule filed April 18, 1975, effective April 28, 1975. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Oct. 30, 2014.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment may cost producers an estimated fifty dollars ($50) to eighty-five dollars ($85) per animal if the producer submits a request for reclassification of the animal that tested positive for Trichomoniasis.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, Linda Hickam, DVM, State Veterinarian, PO Box 630, Jefferson City, MO 65012 or by email to linda.hickam@mda.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name	**2 CSR 30-2.020 Movement of Livestock, Poultry, and Exotic Animals Within Missouri**
Type of Rulemaking	**Proposed**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Per animal	livestock producers	$50 - $85 per animal

III. Worksheet

$50 - $85 per animal

IV. Assumptions

For the producer to have the animals tested prior to change of ownership, it would include (but not limited to): sample collection fee, a trip fee that would vary on the distance from the veterinary clinic to the farm, sample shipping charge to a laboratory for testing, laboratory test charges, and a charge to complete a Certificate of Veterinary Inspection.

The specificity of the test MDA utilizes to analyze samples to determine the presences of the Trichomoniasis pathogen is 99-100%. Therefore, for every 200 test performed we would have an average of one (1) bull that may be classified incorrectly as a positive bull. The proposed rule would enable the owner to submit an appeal and have the bull reclassified pending further investigation and possibly additional testing. It would be difficult to predict how many owners would elect to appeal the test results. We are assuming approximately five (5) owners would appeal on an annual basis. The cost for an additional test would be approximately fifty dollars ($50) eighty-five dollars ($85).

Title 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 6—Livestock Markets

PROPOSED AMENDMENT

2 CSR 30-6.020 Duties and Facilities of the Market/Sale Veterinarian. The director is amending subsection (3)(D).

PURPOSE: This amendment exempts bison from the Trichomoniasis testing requirements, clarifies acceptable laboratories for Trichomoniasis testing, and provides for the animal(s) to be quarantined at the livestock market or at the farm of destination.

(3) Cattle, Bison, and Exotic Bovids.

(D) Trichomoniasis Requirements.

1. All breeding bulls (excluding **bison and** exotic bovines) prior to entering a licensed livestock market/sale shall be—

A. Virgin bulls not more than twenty-four (24) months of age as determined by the presence of both permanent central incisor teeth in wear or by breed registry papers; or

B. Tested negative for Trichomoniasis with an official culture test or official Polymerase Chain Reaction (PCR) test by an *[approved diagnostic]* **official** laboratory within *[thirty (30)]* **sixty (60)** days prior to entry into the state.

(I) Bulls shall be tested three (3) times not less than one (1) week apart by an official culture test or one (1) time by official PCR test prior to entering Missouri.

(II) Bulls that have had contact with female cattle subsequent to testing must be retested prior to entry.

(III) Bulls tested at the market must be quarantined at the farm of destination **or livestock market** pending negative test results. If test results are positive, the positive animals and cohorts will be quarantined.

2. If the breeding bulls are virgin bulls, less than twenty-four (24) months of age, they shall be—

A. Individually identified by official identification; and

B. Accompanied by a breeder's certificate or statement of virgin status signed by the breeder or his representative attesting that they are virgin bulls.

C. The official identification number shall be written on the breeder's certificate.

3. Non-virgin or bulls twenty-four (24) months of age or older must be Trichomoniasis tested with three (3) official culture**s** or one (1) official PCR test. Bulls may be quarantined at farm pending test results. If test results are positive, the positive animal and cohorts will be placed under quarantine.

4. A Certificate of Veterinary Inspection listing official identification and test performed, date of test, results, and laboratory, if testing is required.

5. Bulls going directly to slaughter are exempt from Trichomoniasis testing.

AUTHORITY: section 277.160, RSMo 2000. Original rule filed June 15, 1990, effective Dec. 31, 1990. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed Oct. 30, 2014.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment does not add additional cost for an animal going through a livestock market. For those animals purchased through a livestock market; it may cost the buyer an estimated fifty dollars ($50) to eighty-five ($85) per animal to have the animal tested for Trichomoniasis if the buyer so chooses.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, Linda Hickam, DVM, State Veterinarian, PO Box 630, Jefferson City, MO 65102 or by email to linda.hickam@mda.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE

PRIVATE COST

I. RULE NUMBER

Rule Number and Name	**2 CSR 30-6.020 Duties and Facilities of the Market/Sale Veterinarian**
Type of Rulemaking	**Proposed**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
117	livestock producers	$50 - $85 per animal

III. Worksheet

$50 - $85 per animal

IV. Assumptions

The proposed amendment does not add additional costs to animals going through a livestock market.

However, if an animal is purchased at the market, the market veterinarian would collect the sample for testing and the buyer may be responsible for (but not limited to) sample collection, shipping charges to laboratory for testing, laboratory test charges, and a charge to complete a Certificate of Veterinary Inspection. These charges would vary from each livestock market/sale in Missouri and if the animal was quarantined to the farm of destination or the livestock market.