



Rules of
Missouri Consolidated
Health Care Plan
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

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**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN**

Division 10—Health Care Plan

Chapter 3—Public Entity Membership

22 CSR 10-3.010 Definitions

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

- (1) Accident. An unforeseen and unavoidable event resulting in an injury.
- (2) Active employee. A benefit-eligible person employed by a public entity who meets the plan eligibility requirements.
- (3) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).
- (4) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, and plan changes.
- (5) 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 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, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or
 (C) Rescission of coverage after an individual has been covered under the plan.
- (6) Allowed amount. Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed (see balance billing, section (8)).
- (7) Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.
- (8) Balance billing. When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars (\$100) and the allowed amount is seventy dollars (\$70), the provider may bill the member for the remaining thirty dollars (\$30). A network provider may not balance bill.
- (9) Benefits. Health care services covered by the plan.
- (10) Board. The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).
- (11) Cancellation of coverage. The ending of medical, dental, or vision coverage per a subscriber's voluntary request.
- (12) Claims administrator. An organization or group responsible for processing claims and associated services for a health plan.
- (13) Coinsurance. The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars (\$100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars (\$20). The health insurance or plan pays the rest of the allowed amount.
- (14) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.
- (15) Copayment. A fixed amount, for example, fifteen dollars (\$15), the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.
- (16) Date of service. Date medical services are received.
- (17) Deductible. The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars (\$1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollar (\$1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.
- (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.
- (20) Disease management. A multidisciplinary program designed to educate members with chronic diseases to manage their condition(s).
- (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.
- (22) Effective date. The date on which coverage takes effect.
- (23) Eligibility date. The first day a member is qualified to enroll for coverage.
- (24) Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.
- (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.

(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.

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

(28) Employer. The public entity that employs the eligible employee.

(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.

(30) Excluded services. Health care services that the member’s health plan does not pay for or cover.

(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.

(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.

(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.

(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.

(35) 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.

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

(37) Incident. A definite and separate occurrence of a condition.

(38) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

(39) Lifetime maximum. The amount payable by a medical plan during a covered member’s life for specific non-essential benefits.

(40) Long-term disability subscriber. A subscriber eligible for long-term disability coverage through a public entity’s retirement system.

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

(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.

(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.

(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.

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

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

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

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

(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.

(50) Participant. Shall have the same meaning as the term member defined herein (see member, section (45)).

(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.

(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.

(53) Plan year. The period of January 1 through December 31.

(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.

(55) Premium. The monthly amount that must be paid for health insurance.

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

(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.

(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(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.

(59) Prudent layperson. An individual possessing an average knowledge of health and medicine.

(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.

(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.

(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.

(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.

(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.

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

(66) State. Missouri.

(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.

(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.



(69) Subscriber. The person who elects coverage under the plan.

(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.

(71) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit through a public entity's retirement system.

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

(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.

(74) Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

(75) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits through a public entity's retirement system.

(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).

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**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.020 General Membership Provisions

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

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

(2) Eligibility Requirements.

(A) Active Employee Coverage. An active employee is one who is employed and meets the minimum number of hours worked per year as established by his/her employer.

1. If the public entity allows elected/appointed officials to participate in medical coverage, the definition of an employee includes elected/appointed officials where applicable.

2. The entity will determine the eligibility requirements of waiting periods, required number of working hours, pay status, and contribution levels.

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

4. If an active employee has 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. 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 and his/her spouse/child(ren), provided the employee and his/her spouse/child(ren) have been continuously covered for health care benefits—

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

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

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

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

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

(C) Survivor Coverage.

1. At the time of a vested active employee subscriber's death, his/her survivor(s) may elect to continue coverage if the survivor(s) 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 through group or individual medical coverage for the six (6) months immediately prior to the subscriber's death. In that case, proof of prior group or individual coverage (letter from previous insurance carrier or former employer



with dates of effective coverage and list of persons covered) is required.

2. At the time of a retiree or terminated vested subscriber's death, his/her survivor(s) may elect to continue coverage if the survivor(s) had MCHCP coverage at the time of the subscriber's death.

3. If a survivor subsequently marries and elects to add his/her new spouse to his/her coverage and the survivor dies, the new spouse's 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 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 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 may elect or continue coverage if the terminated vested employee and his/her 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 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 may elect or continue coverage if the employee with long-term disability coverage and his/her 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 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. If the employee's spouse is an active state employee or retiree, s/he may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change, as long as coverage is continuous.

(F) Elected/Appointed Official Coverage.

1. If the public entity allows elected/appointed officials to participate in medical coverage, the definition of an active employee includes elected/appointed officials.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. Active Employee Coverage of a Spouse.

(I) If both spouses have access to MCHCP benefits through two (2) different public entities, the employee and his/her spouse may elect to enroll in coverage separately through his/her respective employer or together through one (1) of the employers. The employee cannot have coverage through both public entities.

(II) If both spouses are employed by the same public entity with access to MCHCP benefits, the employee and spouse may elect coverage either as individuals or under the spouse (if allowed by the employer).

B. Retiree Coverage of a Spouse.

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

2. Children.

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

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

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

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

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

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

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

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. The public entity must enroll or waive coverage for a new employee by submitting a form signed by the employee and the payroll representative within thirty-one (31) days of his/her eligibility date. A new employee's coverage begins on the first day of the month after the hire date and the applicable waiting period.

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period.

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

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

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is estab-

lished shall be the date of the life event; or

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

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

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

E. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the public entity's Human Resource Department of such by mail, phone, or secure message. The corrected form must be submitted to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If an active employee is enrolled and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the employee and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(B) Retiree Coverage.

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

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a separate group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he choos-

es to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

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

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

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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

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

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

6. If a retiree is enrolled and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of



coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the retiree and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(C) Terminated Vested Coverage.

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

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

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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

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

4. If a terminated vested subscriber is enrolled and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of

coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(D) Long-Term Disability Coverage.

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

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

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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

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

4. If a long-term disability subscriber is enrolled and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her depen-

dents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(E) Survivor Coverage.

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

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

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

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

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

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

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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



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

5. If a survivor is enrolled and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the survivor and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(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 with-

in 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 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;

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;

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;

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

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 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 his/her spouse/child(ren) due to a loss of other coverage must submit documentation of proof of loss of coverage for his/her spouse/child(ren) within sixty (60) days of enrollment.

(D) Documentation is also required when a subscriber attempts to terminate a spouse's/child(ren)'s coverage in the case of divorce or death.

(E) The employee is required to notify MCHCP on the appropriate form of the 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 child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence 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 child is still considered disabled by SSA.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage



will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

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

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

(6) Military Leave.

(A) Military Leave for an Active Employee.

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

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

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

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

5. The employee must submit a form within thirty-one (31) days of the employee's return to work to be reinstated for the same level of coverage with the same plan as prior to the leave, 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 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 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;

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.

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

(C) Termination of coverage shall occur immediately upon discontinuance of the plan, subject to the plan termination provision specified in 22 CSR 10-3.080(1).

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

(8) Voluntary Cancellation of Coverage.

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

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

2. A subscriber may reinstate medical coverage after a voluntary cancellation by submitting an Enroll/Change/Cancel/Waive form prior to the end of current coverage.

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

(C) A subscriber cannot cancel medical coverage on his/her 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;
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 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 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 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 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 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 spouse/child(ren) during open enrollment.

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

4. A surviving dependent who 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 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.

(B) Premium Payments.

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

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

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

(C) Required Notifications.

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

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

3. If a COBRA participant is disabled within the first sixty (60) days of COBRA coverage and the disability continues for the rest of the initial eighteen- (18-) month period of continuing coverage, the member must notify MCHCP that s/he wants to continue coverage within sixty (60) days, starting from the latest of: 1) the date on which the SSA issues the disability determination; 2) the



date on which the qualifying event occurs; or 3) the date on which the member receives the COBRA general notice. The member must also notify MCHCP within thirty-one (31) days of any final determination that the individual is no longer disabled.

(D) Election Periods.

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

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

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

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

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

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

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

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

(F) MCHCP assumes coverage for existing COBRA members until their eligibility period expires or until the public entity terminates coverage with MCHCP, whichever occurs first.

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

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

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

2. The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions

and will have to pay the entire premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium.

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

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

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

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

1. A form for election to continue the coverage;

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

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

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

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

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

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

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

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

(12) Medicare.

(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the

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

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

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

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

(14) Communications to Members.

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

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

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

(D) Failure to update a mailing or email address may result in undeliverable mail/email of important informational material, delayed



or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

(15) Deadlines. Unless specifically stated otherwise, MCHCP computes deadlines by counting day one (1) as the first day after the qualifying event. If the last day falls on a weekend or state holiday, the plan administrator may receive required information on the first working day after the weekend or state holiday.

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**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Public Entity Membership Agreement and Participation Period of the Missouri Consolidated Health Care Plan.

(1) The participation agreement, these rules, and applicable provisions of law constitute the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under MCHCP, a public entity agrees that—

1. A public entity must make health care coverage available to all eligible employees, their dependents, former employees entitled to a future retirement benefit, and retirees;

2. MCHCP will be the only health care offering made to its eligible members;

3. The public entity shall contribute at least fifty percent (50%) of the lowest-cost employee-only premium per month toward each active employee's premium for the plan(s) offered through MCHCP. There is no contribution requirement for dependents or retirees;

4. The public entity shall contribute at least fifty percent (50%) toward the employee-only dental premium per month. One hundred percent (100%) of the employees enrolled in the medical plan and fifty percent (50%) of dependents enrolled in the medical plan must participate in the dental plan. The number of employees enrolled in the dental plan must be equal to or exceed the number in the medical plan, but the same employees do not have to be enrolled in both plans;

5. There are no participation or contribution requirements for vision coverage;

6. The Employee Assistance Program is paid by the employer and requires one hundred percent (100%) participation of employees eligible for medical coverage and can be expanded to additional classifications;

7. For public entities with fewer than twenty-five (25) employees, the public entity shall only offer one (1) MCHCP medical plan choice to its employees. For public entities with twenty-five (25) or more employees, the public entity may offer two (2) MCHCP medical plan choices;

8. For public entities with more than a total of three (3) employees, at least seventy-five percent (75%) of all eligible employees must enroll in MCHCP. If an employee declines coverage, s/he must submit a form stating coverage is waived. If the employee is waiving coverage because s/he is covered under another group health plan, Medicare or Medicaid, the employee must submit proof of other coverage. An employee with other group coverage, Medicare, or Medicaid is exempt from the seventy-five percent (75%) enrollment participation requirement. A participation audit will be conducted annually to ensure the participation requirement is met;

9. Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees;

10. A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective; and

11. A public entity must notify MCHCP of a member's termination within thirty (30) days of the termination.

(B) In order to provide retiree coverage, any participating member agency joining MCHCP must have one (1) of the criteria listed below.

1. An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. The employer must offer coverage to retirees who have met this minimum vesting period requirement.

2. An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, in order to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to Missouri State Employees' Retirement System (MOSERS). If this criterion was not met, the employer may not offer coverage to that person as a retiree.

(2) Eligibility Changes.

(A) The following changes can be made prior to open enrollment or fiscal year end:

1. Change the classifications of employees that are offered benefits; or

2. Change the waiting or probationary period that determines when employees are eligible for benefits.

(B) A public entity may change its eligibility requirements during any of the following:

1. Prior to the annual open enrollment period, the public entity must submit the Selection of Offerings form selecting the new requirements. The requirements will go into effect January 1 of the following year;

2. Thirty (30) days prior to the end of its fiscal year. The public entity's top administrator must write a letter requesting the change. The effective date of the change will be the first day of the new fiscal year; or

3. A new employee classification is added to the public entity. The determination of the employee classification for eligibility is at the discretion of the public entity, effective the first day of the month coinciding with or following notification.

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

(4) Premiums. Premiums are billed the fifteenth day of the current month for the next month's coverage. Premiums are due the fifteenth day of the next month or the next business day if the fifteenth falls on a weekend or



holiday. Except for Consolidated Omnibus Budget Reconciliation Act (COBRA) and retiree members, the public entity will be billed and responsible for collecting any premium due directly from the subscriber. COBRA and retiree members are billed directly by MCHCP.

(A) If a retiree or COBRA member is delinquent for two (2) months of premiums and payment is not received by the fifteenth of the month following the delinquency, coverage will be terminated for nonpayment retroactive to the last day of the month for which full premium was received (example: Bill sent September 15 for October premiums and no payment was received; bill mailed October 15 for October and November premiums, due on November 15. If payment is not received, coverage will be terminated due to nonpayment effective September 30). The member will be responsible for the repayment of the services rendered after the retroactive termination date.

(B) If a public entity is delinquent for one (1) month of premiums and the delinquent payment is not received at the end of the month for the month of coverage, coverage for members is terminated for nonpayment on the last day of the month for which full premium was received (example: Bill sent September 15 for October premiums and no payment was received; bill mailed October 15 for November premiums due November 15 and October delinquent premiums due on October 31. If the October premium is not received by October 31, coverage will be terminated due to nonpayment effective September 30). The public entity will be responsible for repayment of the services rendered after the retroactive termination date. A termination of coverage resulting from nonpayment will not relieve the public entity of obligations assumed by the public entity in the Amended and Restated Participation Agreement and under state law. Moneys are due to MCHCP upon or following termination pursuant to Chapter 103, RSMo.

(5) If a subscriber is on a leave of absence, the public entity will be billed the active rate and is responsible for collecting any premium due directly from the subscriber.

(6) Termination Policy.

(A) MCHCP may terminate a public entity for any of the following reasons:

1. Failure to pay premiums;
2. Failure to abide by the terms and conditions of the participation agreement;
3. Failure to maintain participation requirements;
4. Failure to abide by the applicable pro-

visions of Chapter 103, RSMo, or rules and regulations promulgated by MCHCP; or

5. MCHCP ceases to operate.

(B) A public entity may terminate voluntarily with ninety (90) days written notice prior to the end of the plan year, effective January 1 of the following year.

(7) Refunds of overpayments are limited to the amount overpaid during the twelve- (12-) month period preceding the month during which notice of overpayment is received.

*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. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Amended: Filed Oct. 30, 2012, effective May 30, 2013.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.045 Plan Utilization Review Policy

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

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

1. The following medical services are subject to 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 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;

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;

N. Home health care;

O. Hospice care and palliative services;

P. Hospital inpatient services;

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;

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

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

T. Orthognathic surgery;

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

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

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

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

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

Z. Skilled nursing facility;

AA. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery



(including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

BB. 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 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;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of an inpatient admission to certify the necessity of the continued stay in the hospital. Members who have another primary carrier, including

Medicare, are not subject to this provision; and

(C) Retrospective Review—Reviews to determine coverage after services have been provided to a patient. The retrospective review is not limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation, 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. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expired June 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Amended: Filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Amended: Filed Oct. 29, 2014, effective May 30, 2015.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges
(Rescinded June 30, 2011)

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22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges
(Rescinded June 30, 2011)

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22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges
(Rescinded June 30, 2011)

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22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(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).

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



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

(C) 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.

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

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

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

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

(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—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).

(B) Emergency room—two hundred dollars (\$200) network and non-network. Emergency room copayment includes all facility and ancillary medical services received during the emergency room visit. If a member is admitted to the hospital, the copayment is waived and all services apply to the deductible and coinsurance.

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

(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.

(B) Network out-of-pocket maximum for individual—four thousand five hundred dollars (\$4,500).

(C) Network out-of-pocket maximum for family—nine thousand (\$9,000).

(D) Non-network out-of-pocket maximum for individual—ten thousand dollars (\$10,000).

(E) Non-network out-of-pocket maximum for family—thirty thousand dollars (\$30,000).

(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.

(5) Each subscriber will have access to all claim and payment information of the family unit.

(6) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eightieth percentile of usual,

customary, and reasonable fees as determined by the vendor.

(7) 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.

(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.

(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.

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**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges
(Rescinded June 30, 2014)



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22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(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).

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

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

(C) Newborn's claims will be subject to deductible and coinsurance.

(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.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

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

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

(D) Claims shall be paid at eighty percent (80%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability.

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

(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.

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

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

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

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

(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.

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

(4) Each subscriber will have access to all claim and payment information of the family unit.

(5) 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.

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

(7) 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) A subscriber does not qualify for the 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:

- (A) Medicare;
(B) TRICARE;

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

(D) Health reimbursement account (HRA); or

(E) 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.



(9) A subscriber may qualify for this plan even if s/he is covered by any of the following:

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

(10) 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, and section 103.080.3., RSMo Supp. 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. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expired June 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Amended: Filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expired June 29, 2015. Amended: Filed Oct. 29, 2014, effective May 30, 2015.*

**Original authority: 103.059, RSMo 1992 and 103.080, RSMo 2007, amended 2011.*

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges

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

(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).

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

transferred between network and non-network benefits.

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

(C) 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.

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

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

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

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

(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—Network and non-network out-of-pocket maximums are

separate. Expenses cannot be shared or transferred between network and non-network benefits.

(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.

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

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

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

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

(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.

(4) Usual, customary, and reasonable fee allowed—Non-network medical claims are processed at the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor.

(5) Each subscriber will have access to all claim and payment information of the family unit.

(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.

(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.



(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.

(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.

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**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges

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

(1) Benefit Provisions Applicable to the, PPO 600 Plan, PPO 1000 Plan, and Health Savings Account (HSA) Plan. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(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 prior to leaving the network. Benefits eligible for transition of care include:

- (A) Upcoming surgery or prospective transplant;
- (B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;
- (C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;
- (D) Home nursing care;
- (E) Radiation therapy;
- (F) Dialysis;
- (G) Durable medical equipment;
- (H) Cancer treatment;
- (I) Clinical trials;
- (J) Physical, speech, or occupational therapy;
- (K) Hospice care;
- (L) Bariatric surgery, and follow-up per criteria covered under the plan;
- (M) Inpatient hospitalization at the time of the network change;
- (N) Mental health services; or
- (O) Related follow-up services within three (3) months of an acute injury or surgery.

(3) Covered Charges Applicable to the PPO 600 Plan, PPO 1000, and 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 600 Plan, PPO 1000, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. No coverage for no 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 Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

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

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

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

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

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



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

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

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

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

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

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

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

(I) Food or other substances; or

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

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

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

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

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

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

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

(I) Sensitivity to beryllium;

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

(III) Thymoma; and

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

M. Allergy 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;

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 maybe relieved by standard chiropractic treatment in order to restore optimal function;

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

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

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

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

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

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

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

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

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

(II) The member was compliant with a self-directed homecare 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);

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 bat-

teries 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;

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to



sound natural teeth and tissue that are viable, functional, and free of disease; and

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

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

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

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;

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

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;

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;

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;

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;

20. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes



are considered experimental and investigational;

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);

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.

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

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

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

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

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

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

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

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

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

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 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;

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;

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 cov-

erage 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) Inpatient treatment in a network hospital or facility by a non-network provider. Inpatient treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

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 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 chemotherapy;

- (XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

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;

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 vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

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

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;

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;

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;

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 sequelae;

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

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

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

(I) Anteroposterior Discrepancies—

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

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

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

(II) Vertical Discrepancies—

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

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

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

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

(III) Transverse Discrepancies—

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

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

(IV) Asymmetries—

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

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

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

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 goniometer and documented in the medical record;

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

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

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

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

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

VII. Member has plantar fasciitis.

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

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

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

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

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

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

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band



on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

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

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

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

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

(I) Orthopedic footwear;

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

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

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

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

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

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

(a) Acute plantar fasciitis;

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

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

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

(g) Medial osteoarthritis of the knee;

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

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

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

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

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

(a) Hallux valgus deformities;

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

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

(d) Structural deformities such as tarsal coalitions; or

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

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

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

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

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

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

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

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

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

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

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

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

J. Orthopedic Footwear for Diabetic Members.

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

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

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

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

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

(e) Foot deformity of either foot;

or

(f) Poor circulation in either foot.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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;

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;

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_2 max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METs); or

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

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

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;

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

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

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

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

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

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

B. Occupational therapy must meet the following criteria:

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

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

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

C. Speech therapy.



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

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

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

(c) Meaningful improvement is expected;

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

(e) One (1) of the following:

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

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

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

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

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

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

(III) Meals—not covered.

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

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

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Rescinded and readopted: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, terminated May 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency rescission and rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Rescinded and readopted: Filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Amended: Filed Oct. 29, 2014, effective May 30, 2015.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan Limitations

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise, and then only to the extent expressly provided herein or in 22 CSR 10-3.057.

(A) Abortion unless the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(B) Acts of war including—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(C) Alternative therapies—that are outside conventional medicine including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

(D) Assistive listening device.

(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.

(F) Athletic training services.

(G) Autopsy.

(H) Birthing center.

(I) Blood donor expenses.

(J) Blood pressure cuffs/monitors.

(K) Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

(M) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(N) Childbirth classes.

(O) Comfort and convenience items.

(P) Cosmetic procedures.

(Q) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

(R) Devices or supplies bundled as part of a service are not separately covered.



(S) Educational or psychological testing unless part of a treatment program for covered services.

(T) Examinations requested by a third party.

(U) Exercise equipment.

(V) Experimental or investigational services procedures, supplies, or drugs as determined by the claims administrator.

(W) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(X) Services obtained at a government facility if care is provided without charge.

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

(Z) Health and athletic club membership—including costs of enrollment.

(AA) Hearing aid replacement batteries.

(BB) Home births.

(CC) Immunizations requested by third party.

(DD) Infertility treatment beyond the covered services to diagnose the condition.

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

(FF) Long-term care.

(GG) Maxillofacial surgery.

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

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

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

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

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

(KK) Never events—a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(LL) Nocturnal enuresis alarm.

(MM) Other charges as follows:

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

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

3. Charges made in the subscriber's name but which are actually due to the injury

or illness of a different person not covered by the plan; and

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

(NN) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

(OO) Physical fitness.

(PP) Private-duty nursing.

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

(RR) Services not medically necessary.

(SS) Sex therapy.

(TT) Surrogacy—pregnancy coverage is limited to plan member.

(UU) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(VV) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

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

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

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

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

E. Work hardening programs;

F. Back school;

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

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

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

2. Occupational therapy—

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

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

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

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through

another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

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

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

H. Driving safety/driver training; and

3. Speech or voice therapy—

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

B. School speech programs;

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

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

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

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

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

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

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

(WW) Travel expenses.

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

AUTHORITY: section 103.059, RSMo 2000.
Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expired June 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Amended: Filed Oct. 30, 2013, effective June*



30, 2014. Amended: Filed Oct. 29, 2014, effective May 30, 2015.

*Original authority: 103.059, RSMo 1992.

22 CSR 10-3.070 Coordination of Benefits

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

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

(A) This coordination of benefits (COB) provision applies to MCHCP when a member has health care coverage under more than one (1) plan.

(B) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of MCHCP are determined before or after those of another plan. The benefits of MCHCP—

1. Shall not be reduced when, under the order of benefit determination rules, MCHCP determines its benefits before another plan; but

2. May be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

(2) Definitions. The following words and terms, when used in this rule, shall have the following meanings unless the context clearly indicates otherwise:

(A) Allowable expenses.

1. Allowable expense means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered, at least in part, under any of the plans involved, except where a statute requires a different definition.

2. Notwithstanding this definition, items of expense under coverage, such as dental care, vision care, prescription drug, or hearing-aid programs, may be excluded from the definition of allowable expense. A plan which provides benefits only for any of these items of expense may limit its definition of allowable expenses to like items of expense.

3. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

4. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally-accepted medical practice.

5. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of allowable expense must include the corresponding expenses or services to which COB applies.

6. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of this reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

A. Only benefit reductions based upon provisions similar in purpose to those described previously and which are contained in the primary plan may be excluded from allowable expenses.

B. This provision shall not be used to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services;

(B) Claim. A request for benefits of a plan to be provided or paid is a claim. The benefit claimed may be in the form of—

1. Services (including supplies);

2. Payment for all or a portion of the expenses incurred;

3. A combination of paragraphs (2)(B)1. and 2.; or

4. An indemnification;

(C) Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or similar provision takes effect;

(D) Coordination of benefits. This is a provision establishing an order in which plans pay their claims;

(E) Plan includes:

1. Group insurance and group subscriber contracts;

2. Uninsured arrangements of group or group-type coverage;

3. Group or group-type coverage through HMOs and other prepayment, group practice, and individual practice plans;

4. Group-type contracts. Group-type contracts are contracts which are not available

to the general public and can be obtained and maintained only because of membership in, or connection with, a particular organization or group. Group-type contracts answering this description may be included in the definition of plan, at the option of the insurer or the service provider and the contract client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designed (for example, franchise or blanket). Individually underwritten and issued guaranteed renewable policies would not be considered group-type, even though purchased through payroll deduction at a premium savings to the insured, since the insured would have the right to maintain or renew the policy independently of continued employment with the employer. Note: The purpose and intent of this provision are to identify certain plans of coverage which may utilize other than a group contract but are administered on a basis more characteristic of group insurance. These group-type contracts are distinguished by two (2) factors—1) they are not available to the general public, but may be obtained only through membership in, or connection with, the particular organization or group through which they are marketed (for example, through an employer payroll withholding system); and 2) they can be obtained only through that affiliation (for example, the contracts might provide that they cannot be renewed if the insured leaves the particular employer or organization, in which case they would meet the group-type definition). On the other hand, if these contracts are guaranteed renewable allowing the insured the right to renewal regardless of continued employment or affiliation with the organization, they would not be considered group-type;

5. Group or group-type hospital indemnity benefits which exceed one hundred dollars (\$100) per day;

6. The medical benefits coverage in group, group-type, and individual automobile no-fault type contracts but, as to traditional automobile fault contracts, only the medical benefits written on a group or group-type basis may be included; and

7. Medicare or other governmental benefits. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program;

(F) Plan shall not include:

1. Individual or family insurance contracts;

2. Individual or family subscriber contracts;

3. Individual or family coverage under other prepayment, group practice, and individual practice plans;



4. Group or group-type hospital indemnity benefits of one hundred dollars (\$100) per day or less;

5. School accident-type coverages. These contracts cover grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four- (24-) hour basis or on a to-and-from-school basis; and

6. A state plan under Medicaid and shall not include a law or plan when its benefits are in excess of those of any private insurance plan or other non-governmental plan; and

(G) Primary plan/secondary plan. The order of benefit determination rules state whether MCHCP is a primary plan or secondary plan as to another plan covering this person. When MCHCP is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When MCHCP is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two (2) plans covering the person, MCHCP may be a primary plan as to one (1) or more other plans and may be a secondary plan as to a different plan(s).

(3) Order of Benefit Determination Rules.

(A) General. When there is a basis for a claim under MCHCP and another plan, MCHCP is a secondary plan which has its benefits determined after those of the other plan, unless—

1. The other plan has rules coordinating its benefits with those of MCHCP; and

2. Both those rules and MCHCP rules require MCHCP benefits be determined before those of the other plan.

(B) Rules. MCHCP determines its order of benefits using the first of the following rules which applies:

1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);

2. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent;

3. Medicare.

A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal dis-

ease (ESRD) as defined in subparagraph (3)(B)3.C.

B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.

C. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status;

4. Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different persons, called parents—

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;

5. Dependent child/separated or divorced, or never married. If two (2) or more plans cover a person as a dependent child of divorced, separated, or never married parents, benefits for the child are determined in this order—

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child;

C. Then, the plan of the parent not having custody of the child; and

D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

6. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)4.;

7. Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits with itself;

8. The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child; and

9. Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

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

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

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

2. In the case where Medicare is primary for inpatient facility claims, the amount the facility billed is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision. Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicare paid amount. Effective April 1, 2013, Medicare's allowed amount will be used as MCHCP's allowed amount for inpatient facility claims to determine what MCHCP would have paid in absence of this COB provision and the Medicare paid amount will not



longer be combined with the provider's Medicare contractual write off.

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

(5) Right to Receive and Release Needed Information. Certain facts are needed to apply these COB provisions. MCHCP or its claims administrator has the right to decide which facts it needs. MCHCP or its claims administrator may get needed facts from or give them to any other organization or person. MCHCP or its claims administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under MCHCP must give MCHCP or its claims administrator any facts it needs to pay the claim.

(6) A payment made under another plan may include an amount which should have been paid under MCHCP. If it does, MCHCP or its claims administrator may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under MCHCP. MCHCP or its claims administrator will not have to pay that amount again. The term, payment made, includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

(7) If the amount of the payments made by MCHCP or its claims administrator is more than it should have paid under this COB provision, MCHCP or its claims administrator may recover the excess from one (1) or more of—

(A) The person it has paid or for whom it has paid;

(B) Insurance companies; or

(C) Other organizations. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

(8) MCHCP shall, with respect to COB and recoupment of costs, exercise all rights and remedies as permitted by law.

AUTHORITY: section 103.059, RSMo 2000, and section 103.089, RSMo Supp. 2014. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Rescinded and readopted: Filed July 1, 2010, effective Dec. 30, 2010. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emer-*

gency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, terminated May 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Amended: Filed Oct. 29, 2014, effective May 30, 2015.

**Original authority: 103.059, RSMo 1992 and 103.089, RSMo 1992, amended 2011.*

22 CSR 10-3.075 Review and Appeals Procedure

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

(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, 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.

(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.

(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.

(a) If, because of reasons beyond the vendor’s control, more time is needed to review the appeal, 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.

(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.

(a) If, because of reasons beyond the vendor’s control, more time is needed to review the appeal, 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.

(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: 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

(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.

(4) Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by 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

(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 appeal is received within three (3) months of the child's birth date. Valid proof of eligibility must be included with the appeal;

(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 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. Payment 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 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. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009. Amended: Filed Feb. 17, 2010, effective Aug. 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. Emergency amendment filed Jan. 10, 2011, effective Jan. 20, 2011, expired June 29, 2011. Amended: Filed Jan. 10, 2011, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Amended: Filed Nov. 1, 2011, effective Jan. 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expired June 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Amended: Filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Amended: Filed Oct. 29, 2014, effective May 30, 2015.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.080 Miscellaneous Provisions

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

(1) Termination of the Plan. Any other provision of this plan to the contrary notwithstanding, no benefit will be paid for charges incurred by a member or former member after the termination of this plan.



(2) Facility of Payment. Plan benefits will be paid to the subscriber if living and capable of giving a valid release for the payment due. If the subscriber, while living, is physically, mentally, or for any other reason incapable of giving a valid release for any payment due, the claims administrator at his/her option, unless and until request is made by the duly appointed guardian, may pay benefits which may become due to any blood relative, or relative connected by marriage to the subscriber, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the subscriber. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of the payment. Any benefit unpaid at the time of the subscriber's death will be paid to the subscriber's estate. If any benefits shall be payable to the estate of the subscriber, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the subscriber who is deemed by the claims administrator to be equitably entitled to it. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of this payment. Subject to any acceptable written direction and assignment by the subscriber, any benefits provided, at the claims administrator's option, may be paid directly to an eligible provider rendering covered services; but it is not required that the service be rendered by a particular provider.

(3) Confidentiality of Records. The health records of the members in the plan are confidential and shall not be used or disclosed unless such use or disclosure is in compliance with the Health Insurance Portability and Accountability Act.

(4) Should any provision of this plan conflict with the requirements of federal or state law, including, but not limited to, the Health Insurance Portability and Accountability Act, Family and Medical Leave Act, the Americans with Disabilities Act or the Older Workers Benefit Protection Act, the plan shall be administered in such a way as to comply with the requirements of law, and will be deemed amended to conform with law.

(5) The PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan benefits including pharmacy are self-funded by the plan. MCHCP has subrogation rights under section 376.433, RSMo for any amounts expended for these benefits.

(6) 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.

*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. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Amended: Filed Oct. 29, 2014, effective May 30, 2015.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.090 Pharmacy Benefit Summary

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, Health Savings Account (HSA) Plan of the Missouri Consolidated Health Care Plan.

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

(A) PPO 600 and PPO 1000 Prescription Drug Coverage.

1. Network.

A. Generic 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 Hepatitis C specialty drugs and 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;

(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 D₂ or D₃ per dose;

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

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

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

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

3. Out-of-pocket maximum.

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

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

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

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

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Generic: 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.

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 D₂ or D₃ per dose;

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

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

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

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. 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 attempted before the plan will authorize payment for second-step drugs.

(B) Second Step—

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

(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.

(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.

(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.

(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.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, terminated May 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Amended: Filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, terminated May 30, 2015. Amended: Filed Oct. 29, 2014, effective May 30, 2015.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.092 Dental Coverage

PURPOSE: This rule establishes the policy of the board of trustees in regard to dental coverage for members of the Missouri Consolidated Health Care Plan.

(1) The plan administrator may offer dental coverage through a vendor.

(A) Dental plan design is defined by the vendor.

(B) Dental plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-3.020.

(C) Total dental premium costs for all coverage levels are fully paid by the member and/or public entity and collected by the plan administrator.

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. Rescinded and readopted: Filed Nov. 1, 2011, effective May 30, 2012.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.093 Vision Coverage

PURPOSE: This rule establishes the policy of the board of trustees in regard to vision coverage for members of the Missouri Consolidated Health Care Plan.



(1) The plan administrator may offer vision coverage through a vendor.

(A) Vision plan design is defined by the vendor.

(B) Vision plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-3.020.

(C) Total vision premium costs for all coverage levels are fully paid by the member and/or public entity and collected by the plan administrator.

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. Rescinded and readopted: Filed Nov. 1, 2011, effective May 30, 2012.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.100 Fully-Insured Medical Plan Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the fully-insured plan provisions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.

(1) A fully-insured medical plan is subject to applicable Department of Insurance, Financial Institutions and Professional Registration (DIFP) statutes and regulations. Members enrolled in a fully-insured medical plan will have rights and responsibilities as provided in those applicable statutes and regulations. If and to the extent there is a conflict between the plan and DIFP statutes and regulations, DIFP statutes and regulations shall prevail. Governing DIFP statutes and regulations include but are not limited to appeals, time-lines, and payments.

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.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.130 Additional Plan Options (Rescinded January 30, 2014)

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2012. Emergency rule filed Oct. 30, 2012, effective Jan. 1, 2013, expired June 29, 2013. Original rule filed Oct. 30, 2012, effective May 30, 2013. Emergency rescission filed July 16,

2013, effective July 26, 2013, expired Jan. 21, 2014. Rescinded: Filed July 16, 2013, effective Jan. 30, 2014.

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.

(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. Chronic obstructive pulmonary disease—open to those aged eighteen (18) and over;
3. Congestive heart failure—open to those aged eighteen (18) and over;
4. Coronary artery disease—open to those aged eighteen (18) and over;
5. Depression—open to those aged eighteen (18) and over;
6. Diabetes—open to those aged six (6) and over;
7. Musculoskeletal/chronic pain (including low back pain)—open to those aged eighteen (18) and over;
8. Obesity (Body Mass Index \geq 30)—open to those aged eighteen (18) and over; or
9. 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 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, terminated May 30, 2015. Original rule filed Oct. 29, 2014, effective May 30, 2015.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.160 Pharmacy Lock-In Program

PURPOSE: The rule establishes the policy of the board of trustees to implement a method to limit or restrict a member's use of his or her pharmacy benefit to a designated pharmacy.

(1) The Pharmacy Lock-In Program applies to all Missouri Consolidated Health Care Plan's (MCHCP) non-Medicare primary medical plan members that have been identified as misutilizing pharmacy benefits.

(2) Definitions. The following definitions apply to this program:

(A) Misutilization includes, but is not limited to: Seeking excessive or unnecessary medical care from provider(s) and/or in quantities that exceed the levels that are considered medically necessary; the act of lending the pharmacy or medical ID card to non-eligible persons; and submitting forged documents to provider(s) or pharmacies for benefits;

(B) Lock-in: The method to limit or restrict a member to a designated network pharmacy for the filling of specified prescription medication(s); and

(C) Lock-in period: A minimum of twelve (12) months from the effective date of the lock-in program as identified in the confirmation letter from the Pharmacy Benefit Manager (PBM). The lock-in period may be extended if it is determined that the member continues to misutilize benefits.

(3) MCHCP's PBM will identify and review potential cases of pharmacy benefit misutilization.

(4) Once the PBM determines a member has misutilized pharmacy benefits, the PBM will notify the member and refer the member to MCHCP's vendor for case management. The notification process includes:

(A) The PBM will send a letter requesting the member to select one (1) designated network pharmacy location to fill the specified prescription medication(s) from three (3) pharmacy locations identified by the PBM based on the member's demographic area and past prescription fill history;

(B) The member must notify the PBM of his/her pharmacy selection no later than three (3) weeks from the date of the letter;

(C) If the member fails to make a selection, the PBM will choose a pharmacy for the member; and

(D) The PBM will send the member a letter confirming the designated pharmacy and effective date for the lock-in program.

(5) Once locked-in to a designated network pharmacy, prescriptions for controlled substances and muscle relaxants will only be covered if filled at the designated pharmacy and otherwise eligible for payment.

(6) Locked-in members may request a change

to their designated pharmacy. Reasons for approval include, but are not limited to:

(A) The pharmacy is no longer in the member's demographic area;

(B) The pharmacy goes out of business;

(C) The pharmacy is no longer in the PBM network; or

(D) The pharmacy refuses to serve the member.

(7) Pharmacy change request requirements—

(A) Must identify the member's (and dependent's, if applicable) name, the prescribing physician's name, and any applicable reason(s) relevant to the change request, including the reason(s) the member believes his/her designated pharmacy should be changed and any other written documentation to support the member's belief that the pharmacy should be changed;

(B) Must be submitted in writing to:

Express Scripts
Drug Utilization Review Program
100 Parsons Pond Drive
Franklin Lakes, NJ 07417-2603

; and

(C) Pharmacy change requests will be reviewed and decided by the PBM.

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Oct. 29, 2014, effective May 30, 2015.*

**Original authority: 103.059, RSMo 1992.*