



Rules of
Missouri Consolidated
Health Care Plan
Division 10—Health Care Plan
Chapter 2—State Membership

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

22 CSR 10-2.010 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 state members.

- (1) Accident. An unforeseen and unavoidable event resulting in an injury.
- (2) Active employee. A benefit-eligible person employed by the state or agency of the state 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 a 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) Disease management. A program offered to members, who do not have primary Medicare coverage, to help manage certain chronic diseases.
- (19) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:
 (A) Doctor of medicine;
 (B) Doctor of osteopathy;
 (C) Podiatrist;
 (D) Optometrist;
 (E) Chiropractor;
 (F) Psychologist;
 (G) Doctor of dental medicine, including dental surgery;
 (H) Doctor of dentistry; or
 (I) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.
- (20) Effective date. The date on which coverage takes effect.
- (21) Eligibility date. The first day a member is qualified to enroll for coverage.
- (22) Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.
- (23) Emergency medical condition. The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:
 (A) Placing a person's health in significant jeopardy;
 (B) Serious impairment to a bodily function;



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

(D) Inadequately controlled pain; or

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

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

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

(24) Emergency services. With respect to an emergency medical condition—

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

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

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

(26) Employer. The state department or agency that employs the eligible employee.

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

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

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

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

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

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

(F) Prescription drugs;

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

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

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

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

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

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

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

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

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

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

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

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

(32) Health assessment (HA). A questionnaire about a member’s health and lifestyle

habits required for participation in the wellness program.

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

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

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

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

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

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

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

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

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

(42) Medically necessary. The fact that a provider has performed, prescribed, recommended, ordered, or approved a treatment, procedure, service, or supply; or that it is the only available treatment, procedure, service, or supply for a condition, does not, in itself, determine medical necessity. Medically necessary treatments, procedures, services, or supplies that the plan administrator or its



designee determines, in the exercise of its discretion are—

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

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

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

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

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

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

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

(45) 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 10-2.010(19). Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

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

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

under this plan when performed by a physician;

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

(E) Chiropractor;

(F) Licensed Clinical Social Worker;

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP);

or

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

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

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

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

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

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

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

(65) State. Missouri.

(66) Step therapy. Therapy designed to encourage use of therapeutically equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people



who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

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

(68) Subscriber. The employee or member who elects coverage under the plan.

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

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

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

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

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

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

(75) Vendor. The current applicable third-party administrators of MCHCP benefits.

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

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22 CSR 10-2.020 General Membership Provisions

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

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

(2) Eligibility Requirements.

(A) Active Employee Coverage.

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

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

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

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

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



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

(B) Retiree Coverage.

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

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

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

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

2. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

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

5. A retiree who returns to state employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

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

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

(C) Survivor Coverage.

1. At the time of the subscriber's death, a survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits from

MOSERS or PSRS and his/her dependents may elect or continue coverage if the survivor and his/her dependents had coverage—

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

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

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

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

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

4. If a survivor or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days after the first day of the month following the death of the employee, s/he cannot enroll at a later date.

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

(D) Terminated Vested Coverage.

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

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

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

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

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

the terminated vested employee and his/her dependents cannot enroll at a later date.

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

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

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

(E) Long-Term Disability Coverage.

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

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

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

C. Through group or individual medical coverage for the six (6) months immediately prior to becoming eligible for long-term disability benefits. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

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

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



the employee and his/her state employee spouse must be covered individually.

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

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

(F) Elected State Official Coverage.

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

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

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

B. Active Employee Coverage of a Spouse.

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

C. Retiree Coverage of a Spouse.

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

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

2. Children.

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

(I) Natural child of subscriber or spouse;

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

(III) Child legally placed for adop-

tion of subscriber or spouse;

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

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

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

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

(VIII) Newborn of a dependent so long as the parent continues to be covered as a dependent of the subscriber;

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

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

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

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

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim

first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

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

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov within thirty-one (31) days of his/her hire date. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

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

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

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

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

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a dependent, the active employee may enroll the



dependent in an MCHCP plan within sixty (60) days of the court order.

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

A. If an employee is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

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

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

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

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

(B) Retiree Coverage.

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

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

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last

two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

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

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

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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

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

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

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

(I) Retirees enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

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

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

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

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

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

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

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

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

(II) Eligibility for employer-sponsored coverage ends;



(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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

3. If a terminated vested subscriber is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the terminated vested subscriber is currently enrolled in, effective the first day of the next calendar year.

A. If a terminated vested subscriber is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

(I) Terminated vested subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

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

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

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

sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

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

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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

3. If a long-term disability subscriber is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the long-term disability subscriber is currently enrolled in, effective the first day of the next calendar year.

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

(I) Long-term disability subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

B. If a long-term disability subscriber is currently enrolled in the TRICARE Sup-

plemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

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

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

(E) Survivor Coverage.

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

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

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

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

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

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

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



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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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

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

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

(I) Survivors who are enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

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

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

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

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

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her dependents' coverage begins on the first day of the month after enrollment through SEBES. 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. Except for newborns, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP.

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

A. Marriage.

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

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

B. Newborn.

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

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

C. Adoption or placement for adoption.

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

D. Legal guardianship and legal custody.

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

E. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the

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

F. Employee.

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

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

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

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

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

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

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

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

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

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



former state agency's human resource or payroll representative to the new state agency.

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

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

7. An employee who transfers state employment from the Missouri Department of Transportation (MoDOT), Missouri State Highway Patrol, or the Department of Conservation and his/her dependents to another agency with MCHCP benefits will maintain his/her dental and/or vision coverage and may enroll in medical coverage within thirty-one (31) days of transfer. If enrollment is made within thirty-one (31) days of transfer, MCHCP medical coverage is effective with no break in coverage. Dental and vision coverage is continuous throughout the calendar year. An employee cannot enroll in dental and vision at the time of transfer if s/he was not enrolled prior to the transfer.

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

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

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

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or

never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received.

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

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility;

2. Coverage is provided for a newborn of a member from the moment of birth. The member must initially notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date; and

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

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



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

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

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

within sixty (60) days of enrollment.

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

(F) The employee is required to notify

MCHCP on the appropriate form of the dependent's name, birth date, eligibility date, and Social Security number.

(G) Disabled Dependent.

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



twenty-sixth birthday for the currently enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled dependent:

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

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

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

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

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

(6) Military Leave.

(A) Military Leave for an Active Employee.

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

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

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

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

5. The employee must submit a form within thirty-one (31) days of the employee's

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

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

(B) Military Leave for a Retired Member.

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

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

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

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

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

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

(7) Termination.

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

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

2. Entry into the armed forces of any country;

3. With respect to active employee(s) and his/her dependents, termination of employment in a position covered by the

MCHCP, except as expressly specified otherwise in this rule;

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

A. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP 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. The subscriber must submit completed form and a copy of the death certificate within thirty-one (31) days of death;

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

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

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

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

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

(8) Voluntary Cancellation of Coverage.

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

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

2. A subscriber may reinstate medical coverage after a voluntary cancellation by submitting an Enroll/Change/Cancel 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 spouse or children during a divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce. If premiums are collected pre-tax through the Missouri State Employees' Cafeteria Plan (MoCafe), medical coverage can only be cancelled at the time of divorce.

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

1. Upon retirement;
2. When beginning a leave of absence;
- or
3. No longer eligible for coverage.

(9) Continuation of Coverage.

(A) Leave of Absence.

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

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

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

4. Any employee on an approved leave

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

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

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

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

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

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

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

(C) Layoff. An employee on layoff status may continue participation in the plan by paying the required leave of absence premium for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. The employee will receive a letter, enrollment form, and bill from MCHCP. If the employee chooses to continue coverage, s/he must return the enrollment form and payment (if

applicable) to MCHCP within ten (10) days of the date of the letter. If the employee continued coverage in a layoff status, and is two (2) months past due on his/her premiums, coverage on the employee and his/her dependents will be terminated at the end of the month payment was received. If the employee's spouse is an active state employee or retiree, the employee may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. If coverage terminates and the employee is recalled to service, eligibility will be as a new employee. If the employee returns to work with an agency covered by MCHCP, eligibility will be as a new employee. An employee and his/her spouse who is also a state employee must be covered individually.

(D) Workers' Compensation.

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

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

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

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

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

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

3. If the employee does not continue coverage, s/he will be considered a new hire



and may enroll in the plan of his/her choice; or

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

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

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

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

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

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

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

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

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

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage 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 cov-

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

(D) Election Periods.

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

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

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

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

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

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

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group

health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

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

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

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

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

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

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

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

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

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

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

1. A form for election to continue the coverage;

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



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

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

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

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

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

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

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

(12) Medicare.

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

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

(C) 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. If Medicare coverage begins before turning age sixty-five (65) years, 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.

(13) Members are required to annually disclose to the claims administrator whether they have other health coverage and, if so,

information about the coverage. A member may submit other coverage information to the claims administrator by phone, fax, mail, or online. Dependent claims will not be processed until the information is received. Once the information is received, claims will be processed subject to all applicable rules.

(14) Communications to Members.

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

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

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

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

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

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29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 18, 1998, effective Jan. 1, 1999, expired June 29, 1999. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Amended: Filed Dec. 20, 2002, effective June 30, 2003. Emergency amendment filed Dec. 19, 2003, effective Jan. 1, 2004, expired June 28, 2004. Amended: Filed Dec. 19, 2003, effective June 30, 2004. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Amended: Filed Dec. 22, 2005, effective June 30, 2006. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency rescission and 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 rescission and rule filed Oct. 30, 2012, effective Jan. 1, 2013, terminated May 29, 2013. Rescinded and readopted: 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.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.030 Contributions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the contributions made to the Missouri Consolidated Health Care Plan.

(1) Total premium costs for various levels of employee coverage are based on employment status, eligibility for Medicare, and various classifications of dependent participation as



established by the plan administrator.

(2) The employee's contribution toward total premium shall be determined by the plan administrator.

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

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

Medicare Retiree MCHCP contribution = $(2.5\% \times \text{full creditable years of service (up to$

$26 \text{ years}) \times \text{Retiree only PPO 600 Plan total premium}) + \text{Medicare Retiree MCHCP dependent contribution (if any);}$

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

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

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

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

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

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

the Medicare Prescription Drug Only Plan premium. The above calculation can be written by formula as follows: Retiree MCHCP contribution = $2.5\% \times \text{full creditable years of service (up to 26 years)} \times \text{Medicare Prescription Drug Only Plan premium;}$ or

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deduc-

tions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit check deduction is taken for October medical, dental, and vision premiums).

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

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

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

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

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

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

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

2. If there are insufficient funds, MCHCP will send the subscriber a letter and bill requesting payment.

(6) Premium Payments.

(A) By enrolling in coverage under MCHCP, a subscriber agrees that MCHCP may deduct the member's contribution toward the total premium from the subscriber's paycheck. Payment for the first month's premium is made by payroll deduction. Double deductions may be taken to pay for the first month's coverage depending on the date the enrollment is received and the effective date of coverage. Subsequent premium payments are deducted from the subscriber's payroll.

(B) MCHCP will automatically deduct the premium from the retiree or survivor's check. If the retiree or survivor's check is not sufficient to cover the retiree's or survivor's contribution toward total premium, the retiree or survivor will receive a monthly bill. A retiree or survivor may choose to receive a monthly bill in lieu of an automatic deduction from his/her retiree or survivor's check by contacting MCHCP.

1. If the retiree or survivor fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received.

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

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

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

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

*AUTHORITY: section 103.059, RSMo 2000.**



Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expired June 28, 2012. Amended: Filed Nov. 1, 2011, effective May 30, 2012. 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.

*Original authority: 103.059, RSMo 1992.

22 CSR 10-2.040 PPO Plan Summary of Medical Benefits
(Rescinded June 30, 2003)

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, terminated Jan. 14, 2000. Emergency amendment filed Jan. 4, 2000, effective Jan. 14, 2000, terminated Feb. 18, 2000. Emergency amendment filed Feb. 8, 2000, effective Feb. 18, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed

Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Rescinded: Filed Dec. 20, 2002, effective June 30, 2003.

22 CSR 10-2.045 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 Medical Plans.

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

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

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

- A. Ambulance services for non-emergent use, whether air or ground;
- B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;
- C. Applied behavior analysis for autism at initial service;
- D. Auditory brainstem implant (ABI);
- E. Bariatric procedures;
- F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;
- G. Chiropractic services after twenty-six (26) visits annually;
- H. Cochlear implant device;
- I. Chelation therapy;
- J. Dental care to reduce trauma and restorative services when the result of accidental injury;
- K. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;
- L. Genetic testing or counseling;
- M. Home health care;

N. Hospice care and palliative services;

O. Hospital inpatient services except for observation stays;

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

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

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

S. Orthognathic surgery;

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

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

V. Procedures with codes ending in "T";

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

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

Y. Skilled nursing facility;

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

AA. 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 pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents (\$1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications; and

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 conducted after services have been provided to a patient. The retrospective review does not include the review of a claim that is limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment.

*AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2002, effective June 30, 2002. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Amended: Filed Dec.*

20, 2002, effective June 30, 2003. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, 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.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.050 Copay Plan Benefit Provisions and Covered Charges
(Rescinded June 30, 2011)

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Rescinded: Filed Dec. 20, 2002, effective June 30, 2003. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Readopted: Filed Dec. 22, 2005, effective June 30, 2006. 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. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expired June 29, 2011. Rescinded: Filed Dec. 20, 2010, effective June 30, 2011.

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges

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

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

(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 not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(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. 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.

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

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

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

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

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

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

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

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

(4) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security Num-

ber (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

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

(6) Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

(7) Copayments—set charges for the following services apply as long as network providers are utilized. Copayments do not apply to the deductible.

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

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

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

(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.

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

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

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

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 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.*

**Original authority: 103.059, RSMo 1992.*

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

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



(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 not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(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. 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.

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

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

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

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

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

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

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

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

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

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

(6) Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

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

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

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

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. 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.*



*Original authority: 103.059, RSMo 1992.

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges

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

(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) If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

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

(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 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 sixty percent (60%) coinsurance after the deductible. 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.

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

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

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

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

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

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

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

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

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

report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

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

(6) 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.

(7) 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.

(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 10-2.055 and will be subject to any prior authorization requirements provided for in 22 CSR 10-2.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

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

(A) Medicare;

(B) TRICARE;

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



(D) Health reimbursement account (HRA); or

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

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

(12) If a subscriber is enrolled in the HDHP and his/her status changes to Medicare primary during the plan year, the subscriber must enroll in the PPO 300 Plan or PPO 600 Plan within thirty-one (31) days of notice from MCHCP or if no plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan. A new plan deductible and out-of-pocket maximum will apply.

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

(13) 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.

(14) Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the employee must be an active employee on the date the contribution is made and open an HSA with the bank designated by MCHCP.

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

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

Deposit	Subscriber Only	All other coverage levels
January	\$150.00	\$300.00
April (delayed contribution due to health care FSA balance)	\$150.00	\$300.00
July	\$150.00	\$300.00

(C) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP bi-annual contributions will receive a prorated bi-annual contribution. A subscriber will not be able to voluntarily change his/her plan selection after the bi-annual contribution has been deposited into the subscriber’s HSA.

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

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

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

AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2013. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective Jan. 1, 2011, 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.*

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

22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges (Rescinded June 30, 2014)

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. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency rescission filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Rescinded: Filed Oct. 30, 2013, effective June 30, 2014.

22 CSR 10-2.055 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 300 Plan, PPO 600 Plan, and High Deductible Health Plan (HDHP). 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) Disease Management.

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

- 1. Coronary artery disease;
- 2. Diabetes (includes children);
- 3. Asthma (includes children);
- 4. Congestive heart failure;
- 5. Chronic obstructive pulmonary disease;
- 6. Hypertension; or
- 7. Depression with one (1) other disease management condition.

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

- 1. Coronary artery disease;
- 2. Diabetes (includes children);
- 3. Asthma (includes children);
- 4. Congestive heart failure;
- 5. Chronic obstructive pulmonary disease;
- 6. Hypertension with one (1) other disease management condition; or
- 7. Depression with one (1) other disease management condition.

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

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

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

- 1. Prescribed by an appropriate provider for the therapeutic treatment of injury or sickness;
- 2. To the extent they do not exceed any limitation or exclusion; and
- 3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided.

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

- 1. The medical benefits or supplies usually rendered or prescribed for the condition; and
- 2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A provider visit to seek a second opinion.

(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

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

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

- A. Epicutaneous (scratch, prick, or puncture) when 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 photosensitivity disorders;

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

- (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
- (II) Skin testing is unreliable;
- H. Exercise Challenge Testing for exercise-induced bronchospasm;

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

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:

- (a) History of allergy to a particular drug;
- (b) There is no effective alternative drug; and
- (c) Treatment with that drug class is essential;

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

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

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

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen



response assay are covered for evaluation of persons with any of the following suspected conditions:

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

(III) Thymoma; and

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

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

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

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

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

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years. ABA is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;

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

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

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

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

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);

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

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

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

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

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

(VI) Revision of a previous bariatric surgical procedure or conversion to

another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

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

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

C. All of the following criteria have been met:

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

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

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

I. Type II diabetes;

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

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

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

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

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

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



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

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

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

A. Available under the medical plan only—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

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

(IV) Injection; and

(V) Vaginal ring;

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

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

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

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

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

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-

related activities of daily living and/or impairing functional abilities;

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

A. Genetic or hereditary hemochromatosis;

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

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

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

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

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

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

J. Cystinuria;

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

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

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

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

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

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) National Institutes of Health (NIH);

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

(III) Agency for Health Care Research and Quality;



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Radiologic evidence of cochlear ossification;

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

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

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

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

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

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an

existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

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

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

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

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

12. Dental care.

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

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

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

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

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

(I) Colostomy and ureterostomy

bags;

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

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

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

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



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

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

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

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

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

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

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

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

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

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

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

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

17. 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 still-birth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

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

18. 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 inheri-

table disease when all of the following criteria are met:

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

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

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

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

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

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

21. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

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

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

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

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

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

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

A. Home visits instead of visits to the provider's office that do not exceed the usual



and customary charge to perform the same service in a provider's office;

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

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

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

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

F. A home health care visit is defined as—

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

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

(I) Homemaker or housekeeping services;

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

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

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

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

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

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

24. 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/accruited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

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

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

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

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

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

25. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

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

(a) Cornea transplant;

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

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

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

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

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

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

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

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

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

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

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of



the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

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

- (a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;
- (b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);
- (c) A state-licensed psychologist;
- (d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or
- (e) Licensed professional counselor; and

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

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

A. B12 injections are covered for the following conditions:

- (I) Pernicious anemia;
- (II) Crohn's disease;
- (III) Ulcerative colitis;
- (IV) Inflammatory bowel disease;
- (V) Intestinal malabsorption;
- (VI) Fish tapeworm anemia;
- (VII) Vitamin B12 deficiency;
- (VIII) Other vitamin B12 deficiency anemia;
- (IX) Macrocytic anemia;
- (X) Other specified megaloblastic anemias;
- (XI) Megaloblastic anemia;
- (XII) Malnutrition or 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; and

(XXII) Ideopathic progressive polyneuropathy;

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

28. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility. Newborns covered by the PPO 300 or PPO 600 Plan will be subject to deductible and coinsurance if mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance;

29. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary. Does not cover individualized nutritional evaluation

and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program;

30. Nutrition therapy.

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

(I) Anteroposterior Discrepancies—

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

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

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

(II) Vertical Discrepancies—

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

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

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

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

(III) Transverse Discrepancies—

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

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

(IV) Asymmetries—

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

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

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

34. 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 of the following criteria are met:

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

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

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

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

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

(II) AFO and KAFO Not Used During Ambulation.

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

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

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

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

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

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

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

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member

continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

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

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

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

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

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

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

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

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

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

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

(I) Orthopedic footwear;

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

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

(IV) Inserts for a shoe that is an 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;

35. Preventive services.

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

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

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

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

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

F. Cancer screenings—

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

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

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

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered



as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

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

37. 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 Capac-

ity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

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

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

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

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

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

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

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

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

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

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

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

(b) Grade II or worse spondylolisthesis; or

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

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

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

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

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

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

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

B. Occupational therapy must meet the following criteria:

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

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

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

C. Speech therapy.

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

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

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

(c) Meaningful improvement is expected;

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

(e) One (1) of the following:

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

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

42. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan.



Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient’s residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. Travel is limited to a ten thousand dollar (\$10,000) maximum per transplant.

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

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

(III) Meals—not covered.

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

(I) Stem cell transplant—

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

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

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

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

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

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

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

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

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

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

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

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

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

AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment Filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Amended: Filed Dec. 20, 2002, effective June 30, 2003. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency rescission and 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.

*Original authority: 103.059, RSMo 1992.

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations

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

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055.

(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 ene-

mies, 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) Home births.

(BB) Immunizations requested by third party.



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

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

(EE) Long-term care.

(FF) Maxillofacial surgery.

(GG) 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.

(HH) 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.

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

(JJ) Never events—never events are twenty-nine (29) occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(KK) Nocturnal enuresis alarm.

(LL) Not medically-necessary services.

(MM) Orthoptics.

(NN) 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.

(OO) 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.

(PP) Physical fitness.

(QQ) Private-duty nursing.

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

(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, occupation, 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); and

H. Driving safety/driver training;

3. Speech or voice therapy—

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

B. School speech programs;

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

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

E. Maintenance programs of routine, repetitive drills/exercises that do not require

the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

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

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

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

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

(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, and section 103.080.3., RSMo Supp. 2013.
Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1997, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Rescinded: Filed Dec. 20, 2002, effective June 30, 2003. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Readopted: Filed Dec. 22, 2005, effective June 30, 2006. Emergency amendment filed Dec. 21, 2006, effective Jan. 1, 2007, expired June 29,*



2007. Amended: Filed Dec. 21, 2006, effective June 30, 2007. 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. 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.

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

22 CSR 10-2.063 HMO/POS Premium Option Summary of Medical Benefits (Rescinded June 30, 2003)

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Emergency amendment filed Feb. 23, 1998, effective March 5, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, terminated Jan. 14, 2000. Emergency amendment filed Jan. 4, 2000, effective Jan. 14, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003.

Rescinded: Filed Dec. 20, 2002, effective June 30, 2003.

22 CSR 10-2.064 HMO Summary of Medical Benefits (Rescinded June 30, 2011)

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22 CSR 10-2.065 Staff Model Summary of Medical Benefits (Rescinded June 30, 2002)

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. Emergency rescission filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Rescinded: Filed Dec. 17, 2001, effective June 30, 2002.

22 CSR 10-2.067 HMO and POS Limitations (Rescinded June 30, 2010)

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Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Rescinded Filed Dec. 20, 2002, effective June 30, 2003. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Readopted: Filed Dec. 22, 2005, effective June 30, 2006. Emergency amendment filed Dec. 21, 2006, effective Jan. 1, 2007, expired June 29, 2007. Amended: Filed Dec. 21, 2006, effective June 30, 2007. Emergency rescission filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Rescinded: Filed Jan. 4, 2010, effective June 30, 2010.

22 CSR 10-2.070 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 is 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 disease (ESRD) as defined in subparagraph (3)(B)3.D.

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 terminated vested employee with Medicare maintains coverage through one (1) of the MCHCP plans, Medicare is the primary plan and MCHCP is secondary.

D. 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.

E. If a member is on long-term disability through the Missouri State Employees' Retirement System or the Public School Retirement System and is eligible for Medicare, Medicare is the primary plan and MCHCP plan is secondary;

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, 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 High Deductible Health Plan may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision using the following criteria. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

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

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

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

(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. 2013. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004, effective June 30, 2005. Rescinded and readopted: Filed July 1, 2010, effective Dec. 30, 2010. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, 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.*

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

22 CSR 10-2.075 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) General Provision. The board of trustees has the right to suspend, revise, or remove eligibility and benefit requirements in the case of a disaster or emergency situation.

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

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

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

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

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

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

sent by the vendor as soon as possible thereafter.

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

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

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

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

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

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based, with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;



3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

(3) General Appeal Provisions for Medical and Non-Medicare Primary Pharmacy Services.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave rise to the appeal.

(4) Appeal Process for Medical and Non-Medicare Primary Pharmacy Determinations.

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

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

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

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental

or investigational or not medically necessary or appropriate; or

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

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

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

4. External review. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR, Coventry Health Care, and Express Scripts, Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).

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

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

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

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

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 individ-

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

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

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

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

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

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

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

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

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

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level



medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

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

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

(V) For members with medical coverage through UMR—

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

UMR Appeals
PO Box 400046
San Antonio, TX 78229

(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

(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—

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

Coventry Health Care
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210

(b) Expedited appeals must be communicated by (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 consists of one (1) level of internal review provided by the pharmacy vendor.

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

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

Express Scripts
Attn: Pharmacy Appeals—MH3
Mail Route BL0390
6625 W. 78th St.
Bloomington, MN 55439
or by fax to (877) 852-4070

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

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

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

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

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
<http://www.externalappeal.com/>

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

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

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

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

(5) Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the



subscriber's request to enroll his/her newborn or the newborn of an enrolled dependent retroactively to the date of birth if the initial request is made in writing to the board of trustees within three (3) months of the child's birth date. Valid proof of eligibility must be included with the appeal for the request to be considered;

(B) MCHCP may approve a subscriber's appeal and not hold the subscriber responsible when there is credible evidence that there has been an error or miscommunication through the subscriber's payroll/personnel office, MCHCP, or MCHCP vendor that was no fault of the subscriber;

(C) MCHCP may approve an appeal to change the type of medical or vision plan that the subscriber elected during the annual open enrollment period if the request is made within thirty-one (31) calendar days of the beginning of the new plan year, except that no changes will be considered for High Deductible Health Plan elections after the first MCHCP Health Savings Account contribution has been transmitted for deposit to the subscriber's account. This guideline may not be used to elect or cancel coverage or to enroll or cancel dependents. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(D) MCHCP may allow one (1) reinstatement for termination due to non-payment per lifetime of account. The subscriber must include payment in full for all past and current premiums due for reinstatement;

(E) MCHCP may approve a subscriber's appeal to terminate dental and/or vision coverage if the appeal is received within thirty-one (31) calendar days of the beginning of the new plan year and if no claims have been made or paid during the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(F) MCHCP may approve an appeal regarding late receipt of proof-of-eligibility documentation if the subscriber can provide substantiating evidence that it took an unreasonable amount of time for the government agency creating the documentation to provide subscriber with requested documentation;

(G) MCHCP may approve an appeal to change a subscriber's medical plan coverage level prospectively, if the appeal is received within the first thirty (30) days of the start of coverage, except that no changes will be considered for High Deductible Health Plan

selections after the first MCHCP Health Savings Account contributions has been transmitted for deposit to the subscriber's account. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(H) MCHCP may approve a subscriber's appeal to enroll after a deadline due to late notice of loss of coverage from subscriber's previous carrier if the appeal is timely from date of late notice;

(I) 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;

(J) MCHCP may approve an appeal regarding plan changes retrospectively for subscribers who are new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan;

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated;

(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment; and

(M) MCHCP may approve appeals of a late submission of a Preventive Lab form if the subscriber can provide substantiating evidence that the preventive lab screening was received timely, that the subscriber reasonably relied on the health care provider to submit the Preventive Lab form to the wellness vendor, and the health care provider failed to submit the Preventive Lab form to the wellness vendor prior to the May 31 due date.

(7) Medicare Primary Pharmacy Appeals.

(A) Appeals rights and procedures for Medicare primary pharmacy services are provided as regulated by the Centers for Medicare and Medicaid Services. Members may contact the Pharmacy Employer Group Waiver Plan vendor, Express Scripts, for addition-

al information on appeal rights and procedures.

AUTHORITY: section 103.059, RSMo 2000.
Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Amended: Filed Dec. 20, 2002, effective June 29, 2003. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Rescinded and readopted: 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 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.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.080 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.

*AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Amended: Filed Dec. 20, 2002, effective June 29, 2003. Amended: Filed Dec. 19, 2003, effective June 30, 2004. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004, effective June 30, 2005. Amended: Filed Oct. 30, 2012, effective May 30, 2013.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for Medicare-primary members of the Missouri Consolidated Health Care Plan.

(1) The pharmacy benefit for Medicare primary members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(A) The following Medicare primary members enrolled in the PPO 300, PPO 600, or the Medicare Prescription Drug Only Plan shall receive their pharmacy benefit through the Medicare Prescription Drug Plan:

1. Active employee members that have Medicare primary coverage and their enrolled dependents that have Medicare primary coverage; and

2. Retiree members that have Medicare

primary coverage and their enrolled dependents that have Medicare primary coverage.

(B) The non-Medicare primary dependents of Medicare primary members will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(C) Foster parent members that have Medicare primary coverage and their enrolled dependents that have Medicare primary coverage will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(D) A retiree Medicare primary member who chooses not to be in the Medicare Prescription Drug Plan will lose MCHCP eligibility and will not be allowed to enroll in a medical or Medicare Prescription Drug Plan at a later date.

(E) MCHCP will pay the Medicare financial penalty incurred by a Medicare primary member who has had a continuous gap in prescription drug coverage of sixty-three (63) days or more after the Medicare Initial Election Period (IEP) and was not covered by any creditable prescription drug coverage and failed to enroll into Part D.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non-Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicare Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach two thousand eight hundred fifty dollars (\$2,850), the member will pay the following copayments:

A. Generic Formulary Drugs: thirty-one- (31-) day supply has an eight dollar (\$8) copayment; sixty- (60-) day supply has a sixteen dollar (\$16) copayment; ninety- (90-) day supply at retail has a twenty-four dollar (\$24) copayment; and a ninety- (90-) day supply through home delivery has a twenty dollar (\$20) copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a thirty-five dollar (\$35) copayment; sixty- (60-) day supply has a seventy dollar (\$70) copayment; ninety- (90-) day supply at retail has a one hundred five dollar (\$105) copayment; and a ninety- (90-) day supply through home delivery has an eighty-seven dollar and fifty cent (\$87.50) copayment; and



C. Non-preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a one hundred dollar (\$100) copayment; sixty- (60-) day supply has a two hundred dollar (\$200) copayment; ninety- (90-) day supply at retail has a three hundred dollar (\$300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar (\$250) copayment.

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed two thousand eight hundred fifty dollars (\$2,850) and remain below four thousand five hundred fifty dollars (\$4,550), the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach four thousand five hundred fifty dollars (\$4,550);

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach four thousand five hundred fifty dollars (\$4,550), the member will pay the greater of—

A. Five percent (5%) coinsurance or a two dollar and fifty-five cent (\$2.55) copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or a six dollar and thirty-five cent (\$6.35) copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage;

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs; and

6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.

(G) Medications covered under 22 CSR 10-2.090 will be covered under the Medicare Prescription Drug Plan as non-Part D medications when they are not a Part D covered drug.

(H) 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 a Medicare Part B contracted retail pharmacy which is in the pharmacy benefit manager (PBM) network. Medicare Part B prescriptions include, but are not limited to, the following:

1. Diabetes testing and maintenance supplies;
2. Respiratory agents;
3. Immunosuppressants; and
4. Oral anti-cancer medications.

*AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300, PPO 600, HDHP with HSA, and Medicare Supplement Plans 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 physician to non-Medicare primary members.

(A) PPO 300 and PPO 600.

1. Network:

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty-four dollars (\$24) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and one hundred and five dollars (\$105) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) A member must choose how maintenance prescriptions will be filled by notifying the pharmacy benefit manager (PBM) of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

I. If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to thirty-one- (31-) day supply. The first specialty prescription order may be filled through a retail pharmacy.

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

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

(c) Non-formulary copayment: One hundred dollars (\$100) for a drug not on the formulary;

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

F. 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;



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; and

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D₂ or D₃ per dose;

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

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

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

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

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply for a drug not on the formulary.

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

A. Network and non-network out-of-pocket maximums are not separate;

B. The family out-of-pocket maximum is an aggregate of applicable charges

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

C. Individual—six thousand two hundred fifty dollars (\$6,250);

D. Family—twelve thousand five hundred dollars (\$12,500).

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

1. Network:

A. Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

C. Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

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

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

I. If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs covered only through network home delivery for up to thirty-one (31) days.

(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The dosage 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) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

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

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.



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

(A) **First Step**—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First-step drugs must be used 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) **Disease Management (DM) Program Reduced Non-Formulary Prescription Copayments**—

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

1. Fifty-five dollars (\$55) for up to a thirty-one- (31-) day supply for a drug not on the formulary;
2. One hundred ten dollars (\$110) for up to a sixty- (60-) day supply for a drug not on the formulary; and
3. One hundred thirty-seven dollars and fifty cents (\$137.50) for up to a ninety- (90-) day supply for a drug not on the formulary; and

(B) A member is considered actively participating in the DM Program when s/he is enrolled in a DM Program through the medical plan vendor and one (1) of the following:

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

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a DM nurse until the medical plan vendor determines the condition can be managed independently; or

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

(4) **Filing of Claims**—Claims must be filed within twelve (12) months of filling the prescription. A member may request a claim form from the plan or the PBM. In order to file a claim, the member must—

(A) Complete the claim form;

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

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

(C) A member must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted amount as determined by the PBM, less any applicable copayment, deductible, or coinsurance. A member is responsible for any charge over the network discounted price and the applicable copayment.

(5) **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; or

(C) A drug is determined to have a safety issue by the United States Food and Drug Administration (FDA). If this occurs, then the drug is no longer under the pharmacy benefit.

(6) **Grandfathered Specialty Drugs**—Prescription drugs grandfathered for members in

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

(A) Alzheimer's disease drugs;

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

(C) Anti-epileptics;

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

(E) Biologics for inflammatory conditions;

(F) Cancer drugs;

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

(H) Hepatitis drugs;

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

(J) Insulin (basal);

(K) Low molecular weight heparins;

(L) Multiple sclerosis injectable drugs;

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

(N) Phosphate binders;

(O) Pulmonary hypertension drugs; and

(P) Somatostatin analogs.

(7) **Quantity Level Limits**. Quantities of some medications may be limited based on recommendations by the FDA or credible scientific evidence published in peer-reviewed medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

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

(9) **Affordable Care Act (ACA)** required zero dollar drugs. The following drugs are covered at one hundred percent (100%) coverage:

(A) Prescribed over-the-counter nicotine replacement;

(B) Non-formulary brand contraceptive when the individual's health care provider determines that the covered generic would be medically inappropriate for that individual; and

(C) Non-formulary brand contraceptive when a generic version does not exist for one (1) of the FDA-approved contraceptive methods such as barrier, hormonal, or implanted devices.



AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. Emergency rescission filed Dec. 21, 2006, effective Jan. 1, 2007, expired June 29, 2007. Rescinded: Filed Dec. 21, 2006, effective June 30, 2007. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Readopted: 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.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.091 Wellness Program Coverage, Provisions, and Limitations (Rescinded May 30, 2013)

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 20, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Nov. 25, 2011, expired May 22, 2012. Amended: Filed Nov. 1, 2011, effective April 30, 2012. Emergency rescission filed Oct. 30, 2012, effective Jan. 1, 2013, expired June 29, 2013. Rescinded: Filed Oct. 30, 2012, effective May 30, 2013.

22 CSR 10-2.092 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 10-2.020.

(C) Total dental premium costs for all coverage levels are fully paid by the member 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 10-2.093 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 10-2.020.

(C) Total vision premium costs for all coverage levels are fully paid by the member 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 10-2.094 Tobacco-Free Incentive Provisions and Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the tobacco-free incentive benefit.

(1) Eligibility—The following members enrolled in a Missouri Consolidated Health Care Plan (MCHCP) Preferred Provider Organization (PPO) or High Deductible Health Plan (HDHP) are eligible to participate in the tobacco-free incentive:

(A) Active employee subscriber;

(B) Non-Medicare terminated vested subscriber;

(C) Non-Medicare long-term disability subscriber;

(D) Non-Medicare survivor subscriber;

(E) Non-Medicare Consolidated Omnibus Budget Reconciliation Act (COBRA) subscriber;

(F) Non-Medicare retiree subscriber; and

(G) Non-Medicare spouses covered by another tobacco-free incentive eligible sub-

scriber.

(2) Limitations and exclusions—The following members are not eligible to participate in the tobacco-free incentive:

(A) Dependent children;

(B) Dependent children who are covered under a parent's MCHCP plan and who are also state employees;

(C) TRICARE Supplement Plan terminated vested subscriber;

(D) TRICARE Supplement Plan long-term disability subscriber;

(E) TRICARE Supplement Plan survivor subscriber;

(F) TRICARE Supplement Plan COBRA subscriber;

(G) TRICARE Supplement Plan retiree subscriber;

(H) TRICARE Supplement Plan spouses covered by any other eligible subscriber; and

(I) Non-Medicare spouses covered by any tobacco-free incentive ineligible subscriber.

(3) Incentive Participation Requirement.

(A) Each eligible member must participate separately.

(B) To receive the incentive beginning on January 1, 2014, eligible members must do one (1) of the following:

1. Tobacco-free attestation.

A. The member must complete a tobacco-free attestation online through myMCHCP or submit a completed form by fax or mail during the period of October 1, 2013, through November 30, 2013. The form must be received by November 30, 2013; or

2. Tobacco cessation program attestation.

A. The member must complete a tobacco cessation program attestation online through myMCHCP or submit a completed form by fax or mail during the period of October 1, 2013, through November 30, 2013. The form must be received by November 30, 2013. The member also must participate in an MCHCP-approved tobacco cessation program as defined in sections (4) and (5).

(I) If a subscriber and/or his/her spouse become and remain tobacco-free three (3) months prior to May 31, 2014, s/he may continue to receive the incentive through December 31, 2014, if s/he completes a tobacco-free attestation through myMCHCP or submits a completed form by fax or mail by May 31, 2014. The form must be received by May 31, 2014.

(II) If a subscriber and/or his/her spouse completed the tobacco cessation program attestation and does not become tobacco-free three (3) months prior to May 31, 2014, s/he may continue to receive the incentive through December 31, 2014 if s/he completes another tobacco cessation program



attestation online through myMCHCP or submits a completed form by fax or mail by May 31, 2014. The form must be received by May 31, 2014. The member also must again participate in an MCHCP-approved tobacco cessation program as defined in sections (4) and (5).

(C) An employee adding medical coverage with an effective date from November 1, 2013, through May 1, 2014; must complete a tobacco-free attestation or tobacco cessation program attestation within thirty-one (31) days of the subscriber's effective date. A covered spouse's attestation must be completed within thirty-one (31) days of enrollment. The incentive will start on the subscriber's effective date.

1. If a subscriber and/or his/her spouse complete the tobacco cessation program attestation and become and remain tobacco-free three (3) months prior to May 31, 2014, s/he can continue to receive the incentive through December 31, 2014, if s/he completes a tobacco-free attestation through myMCHCP or submits a completed form by fax or mail by May 31, 2014. A form must be received by May 31, 2014.

2. If a subscriber and/or his/her spouse completed the tobacco cessation program attestation and does not become tobacco-free three (3) months prior to May 31, 2014, s/he may continue to receive the incentive through December 31, 2014 if s/he completes another tobacco cessation program attestation online through myMCHCP or submits a completed form by fax or mail by May 31, 2014. The form must be received by May 31, 2014. The member also must again participate in an MCHCP-approved tobacco cessation program as defined in sections (4) and (5).

(D) An employee adding medical coverage with an effective date after May 1, 2014 must do one (1) of the following to receive the incentive:

1. Complete the tobacco-free attestation form online through myMCHCP or submit a completed form by fax or mail to receive the incentive within thirty-one (31) days of the subscriber's effective date. A covered spouse's attestation must be completed within thirty-one (31) days of enrollment. The incentive will start on the subscriber's effective date; or

2. Complete a tobacco cessation program attestation online through myMCHCP or submit a completed form by fax or mail to receive the incentive within thirty-one (31) days of the subscriber's effective date. A covered spouse's attestation must be completed within thirty-one (31) days of enrollment. The incentive will start on the subscriber's effective date. The member also must participate in an MCHCP-approved tobacco cessation program as defined in sections (4) and (5).

(E) A waiver may be granted if a member

provides a physician certification that a medical condition prevents the member from achieving tobacco-free status.

(F) If a member attests to be tobacco-free but starts to use tobacco products, s/he must contact MCHCP through myMCHCP or by phone, fax, or mail immediately to change his/her status. MCHCP will adjust his/her premium for coverage beginning the second month after the member self reports.

(G) The subscriber or his/her spouse is no longer eligible to participate and will lose the partnership incentive the first day of the month in which Medicare becomes his/her primary payer.

(H) The subscriber and his/her spouse are no longer eligible to participate and will lose the partnership incentive the first day of the month in which Medicare becomes the subscriber's primary payer.

(I) MCHCP may audit the attestation for accuracy.

(4) MCHCP-approved tobacco cessation programs for a subscriber are—

(A) Tobacco cessation coaching provided by the wellness vendor.

(B) Strive for Wellness tobacco cessation programs (for active employee subscribers only); or

(C) American Cancer Society Quit for Life: (866-784-8454).

(5) MCHCP-approved tobacco cessation programs for a spouse are—

(A) Missouri Tobacco Quitline: 800-QUIT-NOW (800-784-8669); or

(B) American Cancer Society Quit for Life: (866-784-8454).

(6) MCHCP may utilize participation data for purposes of offering additional programs in accordance with the MCHCP privacy policy.

(7) Tobacco-free incentive—The tobacco-free incentive is forty dollars (\$40) per month per eligible participant.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Nov. 25, 2011, expired May 22, 2012. Original rule filed Nov. 1, 2011, effective April 30, 2012. Emergency amendment filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Amended: Filed Aug. 28, 2012, effective Feb. 28, 2013. Emergency amendment filed Aug. 23, 2013, effective Oct. 1, 2013, expired March 29, 2014. Amended: Filed Aug. 23, 2013, effective March 30, 2014. Emergency amendment filed Feb. 28, 2014, effective May 1, 2014, expired Oct. 27, 2014. Amended: Filed Feb. 28, 2014, effective Aug. 30, 2014.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.095 TRICARE Supplement Plan

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

(1) TRICARE is the Department of Defense's health insurance program for the military community. Primary coverage is through TRICARE with the Missouri Consolidated Health Care Plan TRICARE Supplement Plan paying secondary on claims.

(A) TRICARE Supplement Plan design is defined and provided by the Association and Society Insurance Corporation (ASI).

(B) TRICARE Supplement Plan eligibility, enrollment, and termination requirements are determined by ASI.

(C) Total TRICARE Supplement Plan premium costs for all coverage levels are fully paid by the member and collected by the plan administrator.

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 10-2.100 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.

(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, timelines, 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 10-2.110 General Foster Parent Membership Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the general membership provisions for foster parents covered under 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). A foster parent and his/her dependents 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 the foster parent and seek recovery and/or pursue legal action to the extent the foster parent has provided incomplete, false, or inaccurate information. Purchase of the insurance is at the foster parent's own expense. MCHCP does not contribute toward the premium. The term "foster parent" means any approved specialized foster parent as defined in section 210.543, RSMo, also referred to as Elevated Needs Level B, and licensed under Chapter 210, RSMo, who provides temporary foster care for children who have a documented history of presenting behaviors or diagnoses which render the child unable to effectively function outside of a highly structured setting, not in anticipation of adoption and not for children related to such Elevated Needs Level B foster parent.

(2) Eligibility Requirements.

(A) Foster Parent Coverage. The Department of Social Services shall provide appropriate documentation to MCHCP of initial and ongoing eligibility of a foster parent who qualifies for the purchase of state health insurance. Documentation of eligibility for the purchase of state health insurance shall be required prior to enrollment. A foster parent may enroll dependents as long as the foster parent is also enrolled. In order to be eligible, a foster parent shall not have access to other health insurance coverage through an employer or spouse's employer.

(B) Dependent Coverage. Eligible dependents include:

1. Spouse. If both spouses are eligible foster parents, each spouse must enroll separately;

2. Children.

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

(I) Natural child of subscriber or spouse;

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

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

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

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

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

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

(VIII) Newborn of a dependent so long as the newborn's parent continues to be covered as a dependent of the subscriber; or

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

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

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

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The

second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

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

(3) Enrollment Procedures.

(A) An eligible foster parent must enroll for coverage within thirty-one (31) days from the date of the letter notifying the foster parent of his/her eligibility to enroll. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

(B) An eligible foster parent may elect coverage and/or change coverage levels during the annual open enrollment period.

(C) An eligible foster parent may apply for coverage for himself/herself and/or for his/her dependents if one (1) of the following occurs:

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

2. Employer-sponsored group coverage loss. An eligible foster parent and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

A. Employer-sponsored medical, dental, or vision plan terminates;

B. Eligibility for employer-sponsored coverage ends;

C. Employer contributions toward the premiums end; or

D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

3. If an eligible foster parent or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for coverage of dependent, the eligible foster parent may



enroll the dependent in an MCHCP plan within sixty (60) days of the court order; or

5. If an eligible foster parent is currently enrolled and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the foster parent is currently enrolled in, effective the first day of the next calendar year; or

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

(4) Effective Date Provisions. In no circumstances can the effective date be before the eligibility date or before January 1, 2013. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Eligible Foster Parent and Dependent Effective Dates.

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

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

A. Marriage.

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

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

B. Newborn.

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

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

C. Adoption or placement for adop-

tion.

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

D. Legal guardianship and legal custody.

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

E. Foster care.

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

F. Eligible Foster Parent.

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

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

4. If a foster parent gains state employment, s/he must enroll as a new state employee.

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

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of

eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received.

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

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility. Failure to provide the required documentation within the above stated time frames will result in the dependent being ineligible for coverage until the next open enrollment period;

2. Coverage is provided for a newborn of a member from the moment of birth. The member must initially notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the date of birth. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date;

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

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



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

(B) An eligible foster parent and his/her dependents enrolling due to a loss of employer-sponsored group coverage. The foster parent must submit documentation of proof of loss within sixty (60) days of enrollment. Failure to provide the required documentation within the above stated time frames will result in the foster parent and his/her dependents being ineligible for coverage until the next open enrollment period.

(C) The eligible foster parent is required to notify MCHCP on the appropriate form of the dependent's name, date of birth, eligibil-

ity date, and Social Security number.

(D) Disabled Dependent.

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

permanently disabled dependent:

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

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



C. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the dependent is still considered disabled by SSA.

2. If a disabled child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(E) 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. The member must submit the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical plan.

(6) Termination.

(A) Unless stated otherwise, termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make premium payment for the cost of coverage. If MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, the subscriber will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period;

2. Loss of foster parent licensure as determined by the Department of Social Services;

3. With respect to dependents, upon divorce or legal separation from the subscriber or when a child reaches age twenty-six (26). A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

4. Death of dependent. The dependent's

coverage ends on the date of death. The subscriber must submit a completed form and a copy of the death certificate within thirty-one (31) days of death;

5. A member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

6. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP; or

7. A subscriber has obtained access to other health insurance coverage through an employer or spouse's employer.

(B) MCHCP may rescind coverage due only to non-payment of a premium, fraud, or intentional misrepresentation. MCHCP shall provide at least thirty (30) days written notice before it rescinds coverage.

(C) Termination of coverage shall occur immediately upon discontinuance of the plan, subject to the plan termination provision specified in 22 CSR 10-2.080(1).

(D) If a member receives covered services after the termination of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(E) Termination of a foster parent's coverage shall terminate the coverage of dependents.

(7) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the subscriber notifies MCHCP to cancel coverage.

1. A subscriber may reinstate medical coverage after a voluntary cancellation by submitting an Enroll/Change/Cancel 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 spouse or children during divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce.

(D) A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents if they are no longer eligible for coverage.

(8) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible foster parents and their

dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated eligible foster parents and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Eligible foster parents voluntarily or involuntarily ending licensure as a foster parent (for reasons other than gross misconduct) may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, subscriber may add such eligible dependents to the subscriber's plan if MCHCP is notified within thirty-one (31) days of the marriage, birth, or adoption. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered foster parent becomes eligible for Medicare.

4. A surviving spouse and dependents, who have coverage due to the death of an eligible foster parent, may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced or legally-separated spouse and dependents 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) 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 Department of Social Services Children's Division will notify MCHCP when a foster parent is no longer eligible.

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 affected individual 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 qualified beneficiary receives the COBRA general notice. The affected individual 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 foster parents;

2. Premium for continuation coverage is not paid on time;

3. The covered foster parent or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

4. The covered foster parent or dependent becomes entitled to Medicare after the date s/he elects COBRA coverage; or

5. The covered foster parent 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.

(9) 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 a foster parent whose surviving spouse is eligible for continued coverage or prior to the expiration of a thirty-six- (36-) month COBRA period, the human resource/payroll representative or the surviving spouse shall give MCHCP written notice of the death and the mailing address of the surviving spouse.

(C) Within fourteen (14) days of receipt of the notice, MCHCP shall notify the legally-separated, divorced, or surviving spouse that coverage may be continued. The notice shall include:

1. A form for election to continue the coverage;

2. The amount of premiums to be charged and the method and place of payment; and

3. Instructions for returning the elections form by mail within sixty (60) days after MCHCP mails the notice.

(D) Continuation of coverage terminates on the last day of the month prior to the month the subscriber turns age sixty-five (65). The right to continuation coverage shall also terminate upon the earliest of any of the following:

1. The state of Missouri no longer provides group health coverage to foster parents;

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).

(10) 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.

(11) Communications to Members.

(A) It is the foster parent's responsibility to ensure that MCHCP has current contact information for the member and any dependent(s).

(B) A foster parent 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 foster parents 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.

(12) Deadlines. Unless specifically stated otherwise, MCHCP computes deadlines by counting day one as the first day after the qualifying event. If the last day falls on a weekend or state holiday, MCHCP may receive required information on the first working day after the weekend or state holiday.

(13) Premiums. Notwithstanding any other rule to the contrary, foster parents are responsible for paying the entire actuarial determined rate of total premium with no employer or MCHCP contribution.

AUTHORITY: section 103.059, RSMo 2000, and section 103.078, RSMo Supp. 2013. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. Amended: Filed Oct. 30, 2013, effective June 30, 2014.*

**Original authority: 103.059, RSMo 1992 and 103.078, RSMo 2012.*

22 CSR 10-2.120 Wellness Program

PURPOSE: This rule establishes the policy of the board of trustees in regards to the Strive for Wellness program.

(1) Program—The wellness program is called Strive for Wellness and is administered through a wellness vendor. Strive for Wellness is voluntary. Subscribers are responsible for enrolling, participating, and completing requirements by applicable deadlines.

(2) Eligibility—The following subscribers enrolled in a Missouri Consolidated Health Care Plan (MCHCP) Preferred Provider Organization (PPO) or High Deductible Health Plan (HDHP) are eligible to participate in the wellness program:

- (A) Active employee subscriber;
- (B) Non-Medicare terminated vested subscriber;
- (C) Non-Medicare long-term disability subscriber;
- (D) Non-Medicare survivor subscriber;
- (E) Non-Medicare Consolidated Omnibus

Budget Reconciliation Act (COBRA) subscriber; and

(F) Non-Medicare retiree subscriber.

(3) Limitations and exclusions—The following members are not eligible to participate in the wellness program:

(A) Subscriber under the age of eighteen (18);

(B) Dependent;

(C) Dependent children who are covered under a parent’s MCHCP plan and who are also state employees;

(D) TRICARE Supplement Plan terminated vested subscriber;

(E) TRICARE Supplement Plan long-term disability subscriber;

(F) TRICARE Supplement Plan survivor subscriber;

(G) TRICARE Supplement Plan COBRA subscriber;

(H) TRICARE Supplement Plan retiree subscriber; and

(I) Two (2) married retirees who are enrolled together as a retiree and spouse will be eligible for only one (1) incentive. The retiree in the subscriber status is eligible to participate.

(4) Participation—

(A) Subscribers and new employees may earn an incentive by completing the following:

1. Subscribers—

A. The online Partnership Agreement by November 30, 2013;

B. The online Health Assessment by November 30, 2013; and

C. Complete a preventive lab screening (cholesterol and glucose) between June 1, 2013, and May 31, 2014, and submit the Preventive Lab form to MCHCP’s wellness vendor by May 31, 2014. The vendor must receive the form by May 31, 2014. The form must include the following:

(I) The health care provider’s name and signature;

(II) The subscriber’s name and signature; and

(III) The date the preventive lab screening was completed.

2. New employees—

A. An employee adding medical coverage with an effective date from November 1, 2013, through May 1, 2014, must complete the Partnership Agreement within thirty-one (31) days of the effective date and the Health Assessment by May 31, 2014 or within sixty (60) days of the effective date, whichever is earlier, to receive the partnership incentive. The incentive will start at the beginning of the second month after the eli-

gible subscriber completes the Health Assessment.

B. To continue the incentive July through December 2014, the employee must complete a preventive lab screening (cholesterol and glucose) between June 1, 2013 and May 31, 2014, and submit the Preventive Lab form to MCHCP’s wellness vendor by May 31, 2014. The Partnership Agreement and Health Assessment must be completed by May 31, 2014 or within sixty (60) days of the effective date of coverage, whichever is earlier. The vendor must receive the Preventive Lab form no later than May 31, 2014.

C. An employee with an effective date after May 1, 2014, will be eligible to participate in the wellness program at the next open enrollment period;

(B) Preventive Lab form—

1. Preventive Lab form. The Preventive Lab form is unique for each subscriber and may only be obtained by the subscriber through myMCHCP. The form must be downloaded by each subscriber for his/her use only;

2. Preventive Lab form errors. Forms submitted with errors will not be accepted. Unacceptable errors include, but are not limited to:

A. Form not unique to submitting subscriber;

B. Provider printed name not legible;

C. Provider name or signature missing;

D. Subscriber printed name not legible;

E. Subscriber name or signature missing;

F. Date preventive lab screening completed missing or not legible; and

G. Handwritten changes made to the preprinted name and unique ID contained on the form;

3. Qualified health care provider. The Preventive Lab form must be completed by the health care provider who ordered the preventive lab screening;

(C) Subscribers with disabilities may request special accommodations regarding participation. Appropriately documented reasonable requests will be accommodated to the extent possible;

(D) When Medicare becomes a retiree subscriber’s primary insurance payer, the subscriber is no longer eligible to participate and will lose the partnership incentive the first day of the month in which Medicare becomes primary;



(E) Health Coaching. Subscriber data from the Health Assessment will be used to identify health risks. Subscribers identified to be at moderate to high health risk for weight, eating, stress, exercise, tobacco use, back care, blood pressure, and cholesterol will be offered voluntary phone health coaching to reduce their risk. Health coaching is not required to receive the partnership incentive; and

(F) Subscribers failing to fulfill all requirements of the Partnership Agreement by said deadlines will lose the partnership incentive and will not be eligible for health coaching.

(5) Audit—MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from the wellness program, loss of the partnership incentive, and/or prosecution.

(6) Partnership incentive—The partnership incentive is twenty-five dollars (\$25) per month as reflected in the partnership premium.

(7) Each subscriber is responsible for confirming vendor receipt and acceptability of his/her Preventive Lab form by checking his/her wellness information on myMCHCP. If the information is not reflected within a reasonable time period, it is the subscriber's responsibility to contact the vendor regarding the status of his/her Preventive Lab form.

(8) Coordination of programs—MCHCP and its wellness 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 Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. Emergency amendment filed Aug. 23, 2013, effective Oct. 1, 2013, expired March 29, 2014. Amended: Filed Aug. 23, 2013, effective March 30, 2014.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.130 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 10-2.140 Health Center Provisions, Charges, and Services

PURPOSE: This rule establishes the policy of the board of trustees in regard to provisions, charges, and services available to members of the Missouri Consolidated Health Care Plan (MCHCP) through the MCHCP health center.

(1) Eligibility. Active employees enrolled in an MCHCP medical plan shall be eligible for and able to access the services available at the health center as described in this rule.

(2) Available Services. The health center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:

- (A) Sore throats/ears/headache;
- (B) Strains/sprains/musculoskeletal problems;
- (C) Non-specific abdominal pain;
- (D) Non-specific chest pain;
- (E) Cough;
- (F) Sinus conditions;
- (G) Allergies/allergy injections (maintenance doses only);
- (H) Hormone injections;
- (I) Immunizations including immunization for influenza;
- (J) Rashes;
- (K) Acute urinary complaints;
- (L) Personal hygiene related problems;
- (M) Acute injuries/acute routine office procedures;
- (N) Minor surgical procedures, such as sutures for laceration treatment;
- (O) Ordinary and routine care of the nature of a visit to the doctor's office; and
- (P) Clinical Laboratory Improvement Amendments (CLIA)-waived lab services.

(3) Limitations and Exclusions.

(A) The following employees are not eligible for the health center:

- 1. Active employees who are not enrolled in an MCHCP medical plan;
- 2. Dependents of active employees; and
- 3. Retirees and their dependents.

(B) Services that are beyond the scope of practice of the health center including, but not limited to, the following:

- 1. Emergency services;
- 2. Urgent care services;
- 3. Radiology services;
- 4. Specialist services;

- 5. Pharmacy services;
- 6. Occupational, speech, and physical therapy services; and
- 7. Chiropractic services.

(4) Charges for the following services apply:

(A) Office visit—

1. For active employees enrolled in the MCHCP PPO 300 or PPO 600 Plan, fifteen dollars (\$15) payable at the time of service;

2. For active employees enrolled in the High Deductible Health Plan, forty-five dollars (\$45) payable at the time of service; and

3. The office visit includes the evaluation and management of the patient and any associated laboratory services performed by the health center.

(B) Preventive care—

1. For active employees enrolled in the MCHCP PPO 300 Plan, PPO 600 Plan, or High Deductible Health Plan, preventive care is covered at one hundred percent (100%); and

2. Preventive care shall have the same meaning as in 22 CSR 10-2.055.

(C) Health center services are outside the MCHCP PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan benefits and payments for center services do not apply toward any associated deductible or out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014.*

**Original authority: 103.059, RSMo 1992.*