



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 regarding the key terms within the Missouri Consolidated Health Care Plan relative to state members.

- (1) Accident. An unforeseen and unavoidable event resulting in an injury which is not due to any fault or misconduct on the part of the person injured.
- (2) Actively at work. You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday.
- (3) Administrative appeal. Appeal procedures involving Missouri Consolidated Health Care Plan (MCHCP) administrative issues such as eligibility, effective date of coverage, etc.
- (4) Administrative guidelines. The interpretation of the plan document as approved by the plan administrator, developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.
- (5) Adverse determination. When the claims administrator reviews an admission, availability of care, continued stay or other health care service and decides that it is not medically necessary, appropriate or effective. Therefore, payment for the requested service is denied, reduced or terminated.
- (6) Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible, coinsurance, or table of allowance included in the program.
- (7) Automatic reinstatement maximum. The maximum annual amount that can be reinstated to an individual's lifetime benefit.
- (8) Benefit year. The twelve (12)-month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the benefit year.
- (9) Benefits. Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.
- (10) Care Support Program. A voluntary program that helps manage a chronic condition with outpatient treatment.
- (11) Claims administrator. An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the co-pay plan) and health maintenance organization (HMO) type plans.
- (12) Co-pay plan. A set of benefits similar to a health maintenance organization option.
- (13) Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.
- (14) Covered benefits. A schedule of covered services and charges, including chiropractic services, which are payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.
- (15) Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider or that do not entail or require the continuing attention of trained medical or paramedical personnel.
- (16) Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.
- (17) Dependent-only participation. Participation of certain survivors of employees. Dependent participation may be further defined to include the deceased employee's:
(A) Spouse only;
(B) Child(ren) only; or
(C) Spouse and child(ren).
- (18) Dependents. The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan.
- (19) Diagnostic charges. The Usual, Customary and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.
- (20) Disposable supplies. Do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.
- (21) Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.
- (22) Eligibility date. Refer to 22 CSR 10-2.020 for effective date provisions.
(A) Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.
(B) Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation subject to any applicable pre-existing conditions as outlined in the plan document.
(C) Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.



(D) Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation.

(23) Emancipated child(ren). A child(ren) who is:

- (A) Employed on a full-time basis;
- (B) Eligible for group health benefits in his/her own behalf;
- (C) Maintaining a residence separate from his/her parents or guardian, except for full-time students in an accredited school or institution of higher learning; or
- (D) Married.

(24) Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-2.020(1)(A)3. Dependent participation may be further defined to include the participating employee's:

- (A) Spouse only;
- (B) Child(ren) only; or
- (C) Spouse and child(ren).

(25) Employee only participation. Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents.

(26) Employees. Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law.

(27) Employer. The state department that employs the eligible employee as defined above.

(28) Executive director. The administrator of the Missouri Consolidated Health Care Plan (MCHCP) who reports directly to the plan administrator.

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

- (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, safety, 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.

(30) Formulary drugs. A list of drugs preferred by the claims administrator of the pharmacy program and as allowed by the plan administrator.

(31) Grievance. A written complaint submitted by or on behalf of a member regarding either:

- (A) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or
- (B) Claims payment, handling or reimbursement for health care services.

(32) Health maintenance organization (HMO). A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment.

(33) Home health agency. An agency certified by the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.

(34) Hospice. A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.

(35) Hospital.

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided on its premises, under the supervision of a

staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of (35)(A) of this rule, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home or facility for the aged.

(36) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.

(37) Hospital room charges. The hospital's most common charge for semi-private accommodations, unless a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.

(38) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

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

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

(41) Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice or free-standing chemical dependency treatment center.

(42) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.



- (43) Lifetime. The period of time you or your eligible dependents participate in the plan.
- (44) Lifetime maximum. The maximum amount payable by a medical plan during a covered member's life.
- (45) Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.
- (46) Medically necessary. Treatments, procedures, services or supplies that the plan administrator determines, in the exercise of its discretion:
- (A) Are expected to be of clear clinical benefit to the patient; and
 - (B) Are appropriate for the care and treatment of the injury or illness in question; and
 - (C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a health care provider has prescribed, ordered or recommended a treatment, procedure, service or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service or supply must not be specifically excluded from coverage under this plan.
- (47) Network provider. A physician, hospital, pharmacy, etc., that is contracted with the medical plan.
- (48) Non-formulary. A drug not contained on the health plan's or the pharmacy program's formulary list or preferred drug list.
- (49) Non-network provider or non-participating provider. Any physician, hospital, pharmacy, etc., that does not have a contract with the health plan or the pharmacy program.
- (50) Nurse. A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.
- (51) Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.
- (52) Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.
- (53) Out-of-network. Providers that do not participate in the member's health plan.
- (54) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.
- (55) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.
- (A) Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric nurses and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.
 - (B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.
- (56) Participant. Any employee or dependent accepted for membership in the plan.
- (57) Pharmacy benefit manager (PBM). Acts as a link between the parties involved in the delivery of prescription drugs to health plan members. The PBM designs, implements, manages the overall drug benefit of the plan, and processes claims payments.
- (58) Physically or mentally disabled. The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.
- (59) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo.
- (60) Plan. The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law.
- (61) Plan administrator. The trustees of the Missouri Consolidated Health Care Plan. As such, the board is the sole fiduciary of the plan, 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.
- (62) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.
- (63) Plan year. Same as benefit year.
- (64) Point-of-service (POS). A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized.
- (65) Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.
- (66) Pre-authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service.
- (67) Pre-certification program. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).
- (68) Pre-existing condition. A condition for which you have incurred medical expenses or received treatment within the three (3) months prior to your effective date of coverage.
- (69) Preferred provider organization (PPO). An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers.
- (70) Prevailing fee. The fee charged by the majority of dentists.
- (71) Primary care physician (PCP). A physician (usually an internist, family/general practitioner or pediatrician) who has contracted with and been approved by an HMO or POS. The PCP is accountable for all



medical services of members including referrals. The PCP supervises other provided care such as services of specialists and hospitalization.

(72) Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP.

(73) Proof of insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

(74) Prostheses. An artificial extension that replaces a missing part of the body. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital) or to supplement defective parts.

(75) Provider. Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

(76) Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

(77) Refractions. A record of the patient's preference for the focusing of the eyes that can then be used to purchase eyeglasses. It is the portion of the eye exam that determines what prescription lens provides the patient with the best possible vision.

(78) Rehabilitation facility. A legally operating institution or distinct part of an institution that has a transfer agreement with one or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse or tuberculosis, except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the

jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

(79) Review agency. A company responsible for administration of clinical management programs.

(80) Second opinion program. A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.

(81) Severe obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension or other obesity related conditions which will be considered based on clinical review.

(82) Skilled nursing facility (SNF). An institution which meets fully each of the following requirements:

(A) It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

(B) It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in section (81) of this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).

(83) 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.

(84) Specialty drugs. High cost drugs that are primarily self-injectible but sometimes oral medications.

(85) State. Missouri.

(86) Subrogation. The substitution of one "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 participant and recover the money directly from the other insurer.

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

(88) Survivor. A member who meets the requirements of 22 CSR 10-2.020(5)(A).

(89) Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

(A) Stepchild(ren);

(B) Foster child(ren) for whom the employee is responsible for health care;

(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;

(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

1. Except for a disabled child(ren) as described in section (58) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

(E) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan.

(90) Usual, Customary, and Reasonable charge.

(A) Usual. The fee a physician most frequently charges the majority of his/her patients for the same or similar services.



(B) Customary. The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported.

(91) Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

(92) Vested subscriber. A member who meets the requirements of 22 CSR 10-2.020(5)(B).

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 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 30, 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. Emergency rescission and rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Rescinded and 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. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008.

*Original authority: 103.059, RSMo 1992.

22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

(1) The participant's initial application, any subsequently accepted modifications to such application, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any associated administrative guidelines interpret the subscriber agreement for the benefit of members and administrators but are not a part of the subscriber agreement.

(A) By applying for coverage under the MCHCP a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks;

2. Individual and family deductibles, if appropriate, will be applied; and

3. Any individual eligible as an employee shall not be covered as a dependent unless the employee is on an approved leave of absence.

(2) The effective date of participation shall be determined, subject to the effective date provision in subsection (2)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following

the date of application, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. 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 the plan administrator of the life event;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation. Application for participants must be made in accordance with the following provisions. Effective dates for all dependent coverage is wholly dependent upon paragraph (2)(B)1.

1. Proof of eligibility documentation is required for all dependents. The plan 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 the plan administrator, coverage for the applicable dependent will either be terminated or will never take effect.

A. For the addition of dependents: Required documentation should accompany the application for coverage. Failure to provide acceptable documentation with the application will result in the dependent not having coverage until such proof is received, subject to the deadline noted in part (2)(B)1.A.(I).

(I) If proof of eligibility is not received with the application, such proof will be requested by letter sent to the subscriber. Documentation shall be received no later than thirty (30) days from the date of the letter requesting such proof. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period unless a life event occurs.

2. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death.

3. Acceptable forms of proof of eligibility are included in the following chart:



Circumstance	Documentation
Birth of dependent(s)	<ul style="list-style-type: none"> Birth certificate; or Hospital certificate
Addition of step-child(ren)	<ul style="list-style-type: none"> Marriage license to biological parent of child(ren); and Birth or Hospital certificate for child(ren) that names the subscriber's spouse as a parent
Addition of foster child(ren)	<ul style="list-style-type: none"> Placement papers in subscriber's care
Adoption of dependent(s)	<ul style="list-style-type: none"> Adoption papers; or Placement papers
Legal guardianship of dependent(s)	<ul style="list-style-type: none"> Court-documented guardianship papers (Power of Attorney is not acceptable)
Newborn of covered dependent	<ul style="list-style-type: none"> Birth certificate for subscriber's child(ren); and Birth certificate for subscriber's grandchild(ren)
Marriage	<ul style="list-style-type: none"> Marriage license; Marriage certificate; or Newspaper notice of the wedding
Divorce	<ul style="list-style-type: none"> Final divorce decree; or Notarized letter from spouse stating he/she is agreeable to termination of coverage pending divorce
Death	<ul style="list-style-type: none"> Death certificate

4. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided.

5. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

6. When an employee participating in the plan first becomes eligible with respect to

a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made;

7. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (2)(B)7.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and

8. Survivors, retirees, vested subscribers and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage;

(C) Effective Date Proviso. The effective date of coverage is the first of the month coinciding with or following your eligibility date and the date the form is received by the plan. The effective date of coverage cannot be prior to the date of receipt of the enrollment form by the plan. The effective date for dependent coverage is wholly dependent upon the appropriate proof of eligibility documentation being timely received by the plan (see (2)(B)1.);

(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, sur-

vivors, vested subscribers, or long-term disability subscribers covered under the plan);

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(3) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; or

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (4) and (5).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule or upon failure to provide the plan with acceptable proof of eligibility with the following exception: unemancipated mentally retarded and/or physically handicapped children will continue to be eligible beyond age twenty-five (25) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-fifth birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (5).

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

(5) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if—

1. The active employee was vested and eligible for a future retirement benefit; or

2. Your eligible dependents meet one (1) of the following conditions:



A. They have had coverage through MCHCP since the effective date of the last open enrollment period;

B. They have had other health insurance for the six (6) months immediately prior to your death—proof of insurance is required; or

C. They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility criteria:

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

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in (5)(B)4.; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-

one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity or the Highway Retirement System when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment directly from the leave, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (3)(C). Coverage may be reinstated upon return from military leave without proof of insurability or preexisting conditions. However, the former member

must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(E) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation terminates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (employee only or employee and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment, without proving insurability.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. No pre-existing condition limitation will apply. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase



coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. If the employee participates in a preferred provider organization (PPO) plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.

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

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. 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 if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(7) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if you lose your group health insurance coverage because of a divorce, legal separation or the death of your spouse you may continue coverage until age sixty-five (65) if: a) You continue and maintain coverage under

the thirty-six (36)-month provision of COBRA; and b) You are at least fifty-five (55) years old when your COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

(8) Medicare—Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, 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 was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims;

(B) If a participant eligible for Medicare Part D enrolls in a Medicare Part D plan in addition to coverage under this plan, such participant's coverage may be terminated under this plan in order for the plan to avoid liability for filing a false claim under the subsidy reimbursement portion of Medicare Part D; and

(C) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered 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.

*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 amendment filed March 17, 1997, effective July 1, 1997, expired Sept. 22, 1997. Amended: Filed March 17, 1997, effective Aug. 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. 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.

**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 classes of employee participation based on employment status, eligibility for Medicare and for various classifications of dependent participation are established by the plan administrator.



(2) The contribution by the employee shall be determined by the plan administrator for state employees.

(3) 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.

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.*

**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, effec-

tive 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 utilization review of the Missouri Consolidated Health Care Plan Medical Plans.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate review agency. For emergency hospital admissions, the review agency must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The review agency will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members that require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. (Note:

The utilization review program will be operated in accordance with the administrative guidelines.)

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.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.050 PPO and Co-Pay Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the benefit provisions and covered charges in the Missouri Consolidated Health Care Plan PPO and/or Co-Pay plan.

(1) Deductible amount—per individual for the Preferred Provider Organization (PPO) plan each calendar year, five hundred dollars (\$500), family limit each calendar year, one thousand dollars (\$1,000).

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

(A) The deductible is waived and claims are paid at eighty percent (80%) for the following services: home health care, infusion, durable medical equipment (DME), and audiologists.

(B) Claims may also be paid at eighty percent (80%) if you require covered services that are not available through a network provider in your area. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(C) Non-network claims—seventy percent (70%) of the first four thousand dollars (\$4,000) for an individual, or of the first eight thousand dollars (\$8,000) for a family, of covered charges in the calendar year which are subject to coinsurance. One hundred percent (100%) of any excess covered charges in the calendar year. But see the provision applicable to second opinion, substance



abuse, and mental and nervous conditions, chiropractic care, and PPOs.

(3) Co-payments—set charges for the following types of claims so long as network providers are utilized. Co-payments are no longer charged for the remainder of the calendar year once out-of-pocket maximum is reached with the exceptions noted under (3)(G).

(A) Office visit—twenty-five dollars (\$25).

(B) Laboratory and X-ray services—no co-payment; covered at one hundred percent (100%).

(C) Inpatient hospitalizations—three hundred dollars (\$300) per admission.

(D) Maternity—twenty-five dollars (\$25) for initial visit.

(E) Preventive care—no co-payment; covered at one hundred percent (100%).

(F) Outpatient surgery—seventy-five dollars (\$75).

(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: office visits, emergency room visits, hospital admissions, outpatient surgery, claims for services paid at one hundred percent (100%), charges above the Usual, Customary, and Reasonable (UCR) limit, percentage amount coinsurance is reduced as a result of non-compliance with pre-certification, coinsurance amounts related to infertility benefits, and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year. Certain co-payments do not apply to the out-of-pocket maximum as noted under (3)(G).

(A) Network out-of-pocket maximum for individual—two thousand dollars (\$2,000);

(B) Network out-of-pocket maximum for family—four thousand dollars (\$4,000);

(C) Non-network out-of-pocket maximum for individual—four thousand dollars (\$4,000);

(D) Non-network out-of-pocket maximum for family—eight thousand dollars (\$8,000);

(5) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*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.

**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—In Network: per individual for the High Deductible Health Plan (HDHP) each calendar year, one thousand two hundred dollars (\$1,200), family limit each calendar year, two thousand four hundred dollars (\$2,400). Non-network: per individual for the High Deductible Health Plan (HDHP) each calendar year, two thousand four hundred dollars (\$2,400), family limit each calendar year, four thousand eight hundred dollars (\$4,800).

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the

calendar year once out-of-pocket maximum is reached. Coinsurance is twenty percent (20%) after deductible is met when utilizing network providers. Coinsurance is forty percent (40%) after deductible is met when utilizing non-network providers. Claims may also be paid at eighty percent (80%) if you require covered services that are not available through a network provider in your area. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

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

(A) Network out-of-pocket maximum for individual—two thousand four hundred dollars (\$2,400);

(B) Network out-of-pocket maximum for family—four thousand eight hundred dollars (\$4,800);

(C) Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars (\$4,800);

(D) Non-network out-of-pocket maximum for family—nine thousand six hundred dollars (\$9,600);

(4) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

(5) Prescription costs are applied to the medical plan deductible.

*AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009.*

**Original authority: 103.059, RSMo 1992.*

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 benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

(1) Benefit Provisions.

(A) Subject to the plan provisions and limitations and the written application of the employee, the benefits are payable for covered charges incurred by a participant while covered under the co-pay or preferred



provider organization (PPO) plan, provided the deductible requirement, if any, is met.

(B) Any deductible requirement applies each calendar year to covered charges. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount.

(C) Any family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement.

(D) The total amount of benefits payable for all covered charges incurred out-of-network during an individual's lifetime shall not exceed the lifetime maximum.

(E) If both husband and wife are participating separately as employees under this plan, the family deductible and benefit features shall nevertheless apply to the benefit of the family unit.

(2) Covered Charges.

(A) 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 noncovered service, and which are:

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation;
3. Not excluded by the limitations; and
4. For not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

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

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

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.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.060 PPO, HDHP, and Co-Pay Plan Limitations

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO, HDHP, and/or Co-Pay 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, or within any of the sections of this rule.

(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency or mental and nervous disorder that are not pre-certified as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.

(3) Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(4) Allergy services—no coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy.

(6) Autopsy.

(7) Blood storage, including whole blood, blood plasma and blood products.

(8) Care received without charge.

(9) Comfort and convenience items.

(10) Cosmetic, plastic, reconstructive or restorative surgery—unless medically necessary to repair a functional disorder caused by disease, injury or congenital defect or abnormality (for a participant under the age of nineteen (19)) or to restore symmetry following a mastectomy.

(11) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered.

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

(13) Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

(14) Educational or psychological testing—not covered unless part of a treatment program for covered services.

(15) Examinations requested by a third party.

(16) Exercise equipment.

(17) Experimental services or investigational services—experimental or investigational services, procedures, supplies or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

(18) Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

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

(20) Services obtained at a government facility—not covered if care is provided without charge.

(21) Hair analysis, wigs and hair transplants—services related to the analysis of hair



unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces and hair prostheses, including those ordered by a participating provider are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar (\$200) annual maximum and three thousand two hundred dollar (\$3,200) lifetime maximum.

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

(23) Immunizations requested by third party or for travel.

(24) Infertility—not covered. Those health services and associated expenses for the treatment of infertility including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), *in vitro* fertilization, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.

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

(26) Medical care and supplies—not to the extent that they are payable under—

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

(B) Any state’s cash sickness or similar law including any group insurance policy approved under such law.

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

(28) Military service connected injury or illness.

(29) Non-network providers—subject to deductible and non-network coinsurance.

(30) Not medically necessary services—with the exception of preventive services.

(31) Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe obesity as defined in 22 CSR 10-2.010 and such severe obesity has persisted for at least five (5) years. Bariatric surgery will only be covered when prior authorization is received from the medical

plan. Please see the current State Member Handbook for further limitations regarding bariatric surgery.

(32) Orthognathic surgery.

(33) Orthoptics.

(34) Other charges—no coverage for charges that would not be incurred if you were not covered. Charges for which you or your dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in your name but which are actually due to the injury or illness of a different person not covered by the plan.

(35) Over-the-counter medications—except for insulin through the pharmacy benefit.

(36) Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings and support hose.

(37) Physical fitness.

(38) Pre-existing conditions—not covered for charges associated with pre-existing conditions.

(39) Private duty nursing.

(40) Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related or medically necessary.

(41) Services not specifically included as benefits.

(42) Smoking cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.

(43) Stimulators (for bone growth)—not covered unless authorized by claims administrator.

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

(45) Temporomandibular Joint Syndrome (TMJ).

(46) Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orien-

tation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.

(47) Travel expenses—not covered unless authorized by claims administrator.

(48) Trimming of nails, corns or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease or blindness.

(49) Usual, Customary and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

(50) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions and hematopoietic agents through the pharmacy benefit.

(51) War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot or other circumstances beyond the control of the plan.

(52) Workers’ compensation—charges for services and treatment of an injury incurred during the course of employment and covered by Workers’ Compensation, occupational disease law or similar laws, including all charges to be covered by any associated settlement agreement.

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, 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.

*Original authority: 103.059, RSMo 1992.

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 and POS Summary of Medical Benefits

PURPOSE: This rule establishes the benefit provisions and covered charges in the Missouri Consolidated Health Care Plan HMO and POS plans.

(1) Co-payments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—twenty-five dollars (\$25).

(B) Laboratory and X-ray services—no co-payment; covered at one hundred percent (100%).

(C) Inpatient hospitalizations—three hundred dollars (\$300) per admission.

(D) Maternity—twenty-five dollars (\$25) for initial visit.

(E) Preventive care—no co-payment; covered at one hundred percent (100%).

(F) Outpatient surgery—seventy-five dollars (\$75).

(2) Out-of-pocket maximum—Limited to no more than fifty percent (50%) of the cost of providing a single service. Co-payments are limited to no more than twenty percent (20%) of the cost of providing basic health care services for the total benefit period and may not exceed two hundred percent (200%) of the total annual premium.

(3) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

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 rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expired June 29, 2003. Rescinded: Filed Dec. 20, 2002, effective June 29, 2003. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Readopted: Filed Dec. 22, 2005, effective June 30, 2006.

*Original authority: 103.054, RSMo 1992.

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

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan HMO and/or POS 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, or within any of the sections of this rule.

(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency or mental and nervous disorder that are not pre-certified as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.

(3) Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(4) Allergy services—no coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy.

(6) Autopsy.

(7) Blood storage, including whole blood, blood plasma and blood products.

(8) Care received without charge.

(9) Comfort and convenience items.

(10) Cosmetic, plastic, reconstructive or restorative surgery—unless medically necessary to repair a functional disorder caused by disease, injury or congenital defect or abnormality (for a participant under the age of nineteen (19)) or to restore symmetry following a mastectomy.



(11) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered.

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

(13) Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

(14) Educational or psychological testing—not covered unless part of a treatment program for covered services.

(15) Examinations requested by a third party.

(16) Exercise equipment.

(17) Experimental services or investigational services—experimental or investigational services, procedures, supplies or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

(18) Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

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

(20) Services obtained at a government facility—not covered if care is provided without charge.

(21) Hair analysis, wigs and hair transplants—services related to the analysis of hair

unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces and hair prostheses, including those ordered by a participating provider are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar (\$200) annual maximum and three thousand two hundred dollar (\$3,200) lifetime maximum.

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

(23) Immunizations requested by third party or for travel.

(24) Infertility—Not covered. Those health services and associated expenses for the treatment of infertility including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), *in vitro* fertilization, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.

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

(26) Medical care and supplies—not to the extent that they are payable under—

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

(B) Any state's cash sickness or similar law including any group insurance policy approved under such law.

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

(28) Military service connected injury or illness.

(29) Non-network providers—not covered unless in case of emergency or with prior approval of claims administrator.

(30) Not medically necessary services—with the exception of preventive services.

(31) Obesity—Medical and surgical intervention is not covered, unless the member meets the definition of severe obesity as defined in 22 CSR 10-2.010 and such severe obesity has persisted for at least five (5) years. Bariatric surgery will only be covered when prior authorization is received from the medical

plan. Please see the current State Member Handbook for further limitations regarding bariatric surgery.

(32) Orthognathic surgery.

(33) Orthoptics.

(34) Other charges—no coverage for charges that would not be incurred if you were not covered. Charges for which you or your dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in your name but which are actually due to the injury or illness of a different person not covered by the plan.

(35) Over-the-counter medications—except for insulin through the pharmacy benefit.

(36) Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings and support hose.

(37) Physical fitness.

(38) Pre-existing conditions—not applicable to health maintenance organization (HMO) coverage.

(39) Private duty nursing.

(40) Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related or medically necessary.

(41) Services not specifically included as benefits.

(42) Smoking cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.

(43) Stimulators (for bone growth)—not covered unless authorized by claims administrator.

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

(45) Temporomandibular Joint Syndrome (TMJ).

(46) Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to



sex transformation. Also excludes hormonal support for sex transformation.

(47) Travel expenses—not covered unless authorized by claims administrator.

(48) Trimming of nails, corns or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease or blindness.

(49) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions and hematopoietic agents through the pharmacy benefit.

(50) War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot or other circumstances beyond the control of the plan.

(51) Workers' compensation—charges for services and treatment of an injury incurred during the course of employment and covered by Workers' Compensation, occupational disease law or similar laws, including all charges to be covered by any associated settlement agreement.

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. 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.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.070 Coordination of Benefits

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

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

(2) As used in this rule—

(A) Plan means a plan listed in the following which provides medical, vision, dental or other health benefits or services:

1. A group or blanket plan on an insured basis;
2. Other plan which covers people as a group;
3. A self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. A prepayment group plan which provides medical, vision, dental or health services;
5. Government plans, including Medicare;
6. Auto insurance when permitted by the laws of the state of jurisdiction; and
7. Single- or family-subscribed plans issued under a group- or blanket-type plan;

(B) The definition of plan shall not include:

1. Hospital preferred provider organization (PPO) type plans;
2. Types of plans for students; or
3. Any individual policy or plan;

(C) Each plan, as defined previously, is a separate plan. However, if only a part of the plan reserves the right to adjust its benefits due to other coverage, the portion of the plan which reserves the right and the portion which does not shall be treated as separate plans;

(D) Allowable expense means a necessary, reasonable and customary item of medical, vision, dental or health expense which is covered at least in part under one of the plans. If a plan provides benefits in the form of services, the cash value of such service will be deemed to be the benefit paid. An allowable expense to a secondary plan includes the

value or amount of any allowable expense which was not paid by the primary or first paying plan; and

(E) Benefit determination period means from January 1 of one year through December 31 of the same year.

(3) The benefits under the policy shall be subject to the following:

(A) This provision shall apply in determining the benefit as to a person covered under the policy for a benefit determination period if the sum of paragraphs (3)(A)1. and 2. listed in this rule exceeds the allowable expense incurred by or on behalf of such person during the period—

1. The benefits payable under this plan in the absence of this provision; and

2. The benefits payable under all other plans in the absence of provisions similar to this one;

(B) As to any benefit determination period, the allowable expense under this plan shall be coordinated, except as provided in subsection (3)(C) of this rule, so that the sum of such benefits and all of the benefits paid, payable or furnished which relate to such allowable expense under other plans, shall not exceed the total of allowable expenses incurred by the covered individual. All benefits under other plans shall be taken into account whether or not claim has been made;

(C) If coverage under any other plan is involved, as shown in subsection (3)(B) of this rule—

1. This plan contains a provision coordinating benefits with other plans; and

2. The terms set forth in subsection (2)(D) would require benefits under this plan be figured before benefits under the other plan are figured, the benefits under this plan will be determined as though other plans were not involved;

(D) The basis for establishing the order in which plans determine benefits shall be as follows:

1. Benefits under the plan which cover the person on whom claim is based as an employee shall be determined before the benefits under a plan which cover the person as a dependent; and

2. The primary plan for dependent children will be the plan of the parent whose birthday occurs first in the calendar year. If both parents have the same birthday, the plan of the person who has been covered the longest period of time becomes the primary carrier:

A. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the



parent with custody of the child will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody;

B. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; and

C. In spite of subparagraphs (3)(D)2.A. and B. of this rule, if there is a court decree which would otherwise decide financial duty for the medical, vision, dental or health care expenses for the child, the benefits of a plan which covers the child as a dependent of the parent with such financial duty shall be decided before the benefits of any other plan which covers the child as a dependent; and when paragraphs (3)(D)1. and 2. of this rule do not establish the order of benefit determination, the plan which covers the person for the longer time shall be determined first; and

(E) When this provision operates to reduce the benefits under this plan, each benefit that would have otherwise been paid will be reduced proportionately and this reduced amount shall be charged against the benefit limits of this plan.

(4) When a member has coverage with two (2) group plans, the plan which covers the person for the longer time shall be determined first.

(5) If a member is eligible for Medicare due to a disability, Medicare is the primary plan and this plan is a secondary plan. If a member or dependent is eligible for Medicare due to end stage renal disease, this plan is primary for the first thirty (30) months. Medicare is primary after the first thirty (30) months.

(6) The claims administrator, with the consent of the employee or the employee's spouse when the claim is for a spouse, or the parent or guardian when the claim is for a minor child, may release or obtain any data which is needed to implement this provision.

(7) When payments should have been paid under this plan but were already paid under some other plan, the claims administrator shall have the right to make payment to such other plan of the amount which would satisfy the intent of this provision. This payment shall discharge the liability under this plan.

(8) When payments made under this plan are in excess of the amount required to satisfy the intent of this provision, the claims administrator shall have the right to recover the excess payment from one (1) or more of the following:

- (A) Any person to whom, for whom or with respect to whom these payments were made;
- (B) Any insurance company; or
- (C) Any other organization.

(9) The claims administrator will pay benefits promptly, or, if applicable, within their contractual time frame obligations after submittal of due proof of loss unless the claims administrator provides the claimant a clear, concise statement of a valid reason for further delay which is in no way connected with, or caused by the existence of this provision nor otherwise caused by the claims administrator.

(10) If one of the other plans involved (as defined in coordination of benefits provision) provides benefits on an excess insurance or excess coverage basis, subsections (3)(C) and (D) of this rule shall not apply to the plan and this policy will pay as excess coverage.

*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 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.*

**Original authority: 103.059, RSMo 1992.*

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 the Missouri Consolidated Health Care Plan.

(1) When any participant shall suffer any injury or sickness giving rise to claim under

these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

(2) The plan administrator, agent or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which request is made.

(3) Written proof of claims incurred should be furnished to the claims administrator 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 claims administrator before they are paid.

(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

(5) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO), or co-pay health plan contractor or claims administrator applicable to the member. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan Board of Trustees to review the decision of the health plan contractor or claims administrator.

(A) Appeals to the board of trustees shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved and be addressed to:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110



(B) The board may utilize a hearing officer, such as the Administrative Hearing Commission, to conduct a fact-finding hearing, and make proposed findings of fact and conclusions of law.

1. The hearing will be scheduled by the MCHCP.

2. The parties to the hearing will be the insured and the applicable health plan.

3. All parties shall be notified in writing of the date, time and location of the hearing.

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.

5. The party appealing to the board shall carry the burden of proof.

6. The independent hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions and recommendations shall be sent to all parties.

(C) The board may, but is not required to, review the transcript of the hearing. It will review the summary of evidence, the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision within thirty (30) days of its receipt, as provided in sections 536.100 to 536.140, RSMo.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.

4. In reviewing these appeals, the board and/or staff may consider:

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

B. Credible evidence—Notwithstanding any other rule, the MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office or the MCHCP, that was no fault of the member.

C. Change of plans due to dependent change of address—A member may change plans outside the open enrollment period if his/her covered dependents move out of state and their current plan cannot provide coverage.

(E) Any member wishing to appeal their enrollment selection completed during the annual open enrollment period must do so in writing to the board of trustees within thirty (30) calendar days of the beginning of the new plan year. The MCHCP will respond within thirty (30) calendar days of the receipt of the appeal.

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. Amend-*

ed: Filed Dec. 22, 2008, effective June 30, 2009.

**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 participant or former participant after the termination of this plan.

(2) Facility of Payment. Plan benefits will be paid to the employee if living and capable of giving a valid release for the payment due. If the participant, 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 participant, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the participant. 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 employee's death will be paid to the employee's estate. If any benefits shall be payable to the estate of the employee, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the employee 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 employee, 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 participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to



the officers and employees of the plan or claims administrator or his/her legal representatives who have a need for the records in the performance of their duties; or unless disclosure would be for a routine use by the plan or claims administrator for a purpose which is compatible with the purpose for which it was collected; or unless disclosure of the records would be to the commissioner of administration, or his/her legal representative, for the sole purpose of preventing fraudulent or redundant medical claims to either the Missouri Consolidated Health Care Plan, Missouri, or other public entities as an employer or self-insurer of Workers' Compensation for use in the investigation of a Workers' Compensation claim; or unless disclosure of the records is to the participant to whom the record pertains; or unless disclosure of the record is pursuant to the order of a court of competent jurisdiction. The parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity by a court of competent jurisdiction, may act on behalf of the individual.

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

(5) This document will be kept on file at the principal offices of the plan administrator and may be inspected by a participant during regular business hours. Also, the plan administrator reserves the right at any time to modify or amend, in whole or in part, any or all provisions of the plan.

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 amend-*

ment 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.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.090 Pharmacy Benefit Summary
(Rescinded June 30, 2007)

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.