



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

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**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

22 CSR 10-3.010 Definitions

PURPOSE: This rule establishes the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan relative to public entities and public entity members.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) When used in this chapter's rules or the public entity member handbook, these words and phrases have the meaning—

(A) Accident—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;

(B) 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;

(C) 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;

(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12)-month period beginning January 1 and ending December 31;

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator;

(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;

(H) Claims administrator—An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs and preferred provider organization (PPO);

(I) Cosmetic surgery—A procedure performed primarily to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury;

(J) Covered benefits—A schedule of covered services and charges, including chiropractic services, which are payable under the plan;

(K) Custodial care—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;

(L) Dependent-only participation—Participation of certain survivors of employees. Dependent participation may be further defined to include the deceased employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren);

(M) 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;

(N) Eligibility date—Refer to 22 CSR 10-3.020 for effective date provisions.

1. 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 eligibility as determined by the employer.

(O) Emancipated child(ren)—A child(ren) who is—

1. Employed on a full-time basis;
2. Eligible for group health benefits in his/her own behalf;

3. 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

4. Married;

(P) Employee and dependent participation—Participation of an employee and the employee's eligible dependents. Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren). Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-3.030(1)(A)9.;

(Q) Employee only participation—Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents;

(R) Employees—Employees of the participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity;

(S) Employer—The public entity that employs the eligible employee as defined above;

(T) Executive director—The administrator of the Missouri Consolidated Health Care Plan (MCHCP) who reports directly to the plan administrator;

(U) Health maintenance organization (HMO)—An organization that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;

(V) 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;

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

(X) Hospital.

1. 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.

2. An institution not meeting all the requirements of (1)(X)1. of this rule, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

3. 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).



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

5. 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. 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;

(Y) Lifetime—The period of time you or your eligible dependents participate in the plan;

(Z) Medical benefits coverage—Services that are received from providers recognized by the plan and are covered benefits under the plan;

(AA) Medically necessary—Services and/or supplies usually rendered or prescribed for the specific illness or injury;

(BB) 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;

(CC) 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;

(DD) 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;

(EE) Out-of-network—Providers that do not participate in the member’s health plan;

(FF) Participant—Any employee or dependent accepted for membership in the plan;

(GG) 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;

(HH) Physician/Doctor—A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo;

(II) Plan—The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law;

(JJ) Plan administrator—The trustees of the Missouri Consolidated Health Care Plan;

(KK) Plan document—The statement of the terms and conditions of the plan as adopted by the plan administrator in the “2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook” with respect to dental and vision coverage and incorporated by reference in this rule, as published in August 2004 by the Missouri Consolidated Health Care Plan, PO Box 104355, Jefferson City, MO 65110. This rule does not incorporate any subsequent amendments or additions. Note: The plan documents for medical plans are provided by the fully-insured contractors of such plans, and such plan documents may be obtained by contacting those contractors directly. The names, addresses, and phone numbers of the fully-insured contractors may be found in the “2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook”;

(LL) Plan year—Same as benefit year;

(MM) 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;

(NN) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;

(OO) 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;

(PP) Prior plan—The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP;

(QQ) 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;

(RR) Public entity—A state-sponsored institution of higher learning, political subdivision or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board;

(SS) Review agency—A company responsible for administration of clinical management programs;

(TT) Second opinion program—A consultation and/or exam with a physician qualified to perform the procedure who is not affiliat-

ed with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service;

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

1. 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;

2. 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

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(UU) 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);

(VV) State—Missouri;

(WW) Subscriber—The employee or member who elects coverage under the plan;

(XX) Survivor—A member who meets the requirements of 22 CSR 10-3.020(6)(A);

(YY) 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:

1. Stepchild(ren);

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

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

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. Except for a disabled child(ren) as described in subsection (1)(GG) 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 10-3.020(4)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

5. 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;

(ZZ) Usual, customary, and reasonable charge—

1. Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services;

2. Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

3. Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

4. 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; and

(AAA) Vested subscriber—A member who meets the requirements of 22 CSR 10-3.020(6)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 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 10-3.020 Subscriber Agreement and General Membership Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the employee's subscriber 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 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; and

2. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the prior plan may be credited for those joining one of the preferred provider organization (PPO) options. Appropriate proof of said deductibles will be required.

(2) The participation period shall begin on the participant's effective date in the plan. Participation shall continue until this plan or coverage in this rule is terminated for any reason. However, transfer from the prior plan to this plan will be automatic upon the effective date of this plan.

(3) The effective date of participation shall be determined, subject to the effective date provision in subsection (3)(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. 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.

1. 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;

2. 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;

3. 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 (3)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and

4. 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.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity;

(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, survivors, vested subscribers, or long-term disability subscribers covered under the plan); and

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

(4) 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 (5) and (6).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule 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 (6).

(5) 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).

(6) 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 retirement system of the participating public entity 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 (7)(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 retirement system of the participating public entity when s/he reaches retirement age. 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 (5)(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 ben-

efits. 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 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.

(7) 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.

(8) 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.

(9) 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; and

(B) 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. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. 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 10-3.030 Public Entity Membership Agreement and Participation Period

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



(1) The application packet, participation agreement, and confirmation notice shall comprise the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

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

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

2. If the public entity participated in the MCHCP during calendar year 2004 and continues to participate each year subsequent to calendar year 2004, that public entity shall only be required to contribute twenty-five dollars (\$25) per month towards the employee only premium for each active employee's premium for the plan(s) offered through MCHCP during calendar years 2005 and 2006;

3. If the public entity did not participate in the MCHCP during calendar year 2004, that public entity shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

4. Beginning January 1, 2007, all public entities shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

5. For public entities with less than twenty-five (25) employees, the public entity shall only offer one (1) plan choice to its employees. For public entities with twenty-five (25) or more employees, the public entity may offer more than one (1) plan choice provided by MCHCP.

6. For public entities with more than a total of three (3) employees, at least seventy-five percent (75%) of all eligible employees must join the MCHCP. For public entities with three (3) or fewer employees, a minimum of one (1) employee must join the MCHCP. For public entities with three (3) or fewer employees who fail to have one (1) employee participating in the MCHCP, MCHCP will allow the public entity up to the remainder of the period remaining in the latest participation agreement in which to attempt to meet the participation requirements before terminating for failure to meet the participation requirements;

7. Individual and family deductibles, if applicable, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining one of the PPO options. Appropriate proof of said deductibles will be required;

8. An eligible employee is one that is not covered by another group sponsored plan;

9. Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees in consideration of section (6); and

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

(B) Effective January 1, 2001, in order to provide retiree coverage, any participating member agency joining MCHCP must have one of the criteria listed below. If neither of these scenarios is applicable and no retirement plan exists, no "retirees" would exist, so there would be no retiree eligibility.

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

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

(2) The public entity's participation period shall begin on the date specified in the participation agreement. Participation shall continue until the end of the participation agreement is reached or immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-3.080(1).

(3) The voluntariness of the public entity's failure to meet participation levels is to be determined by MCHCP. Examples of non-voluntary failure to meet participation levels include: 1) a public entity falls below the required participation level due to employment termination(s); and 2) a public entity falls below the required participation level, but the public entity can prove that all eligible employees who failed to take the coverage have other group coverage not offered through the public entity or are Medicare eligible.

(4) Total premium costs for various classes of employee participation based on employment status, eligibility for Medicare, and for vari-

ous classifications of dependent participation are established by the plan administrator.

(5) Underwriting guidelines are set by the plan administrator.

(6) The contribution by the employee shall be determined, within the underwriting guidelines set by the plan administrator, by the appropriate administrative unit for the public entity.

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.070 Coordination of Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to 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 service;
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 submission 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. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005.*

**Original authority: 103.059, RSMo 1992.*



22 CSR 10-3.075 Review and Appeals Procedure

PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in 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), or preferred provider organization (PPO) 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, 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. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.080 Miscellaneous Provisions

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

(1) Termination of the Plan. Any other provision of this plan to the contrary notwithstanding, no benefit will be paid for charges incurred by a 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. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005.*

**Original authority: 103.059, RSMo 1992.*