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SALUS POPULI SUPREMA LEX ESTO

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

ROBIN CARNAHAN

SECRETARY OF STATE

# MISSOURI REGISTER

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# MISSOURI REGISTER

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

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

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

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

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

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

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

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

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

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

### EMERGENCY AMENDMENT

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

*PURPOSE: Under the Annual Adjusted Rate of Interest (section 32.065, RSMo), this amendment establishes the 2012 annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2012.*

*EMERGENCY STATEMENT: The director of revenue is mandated to establish not later than October 22, an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percent. This emergency amendment is necessary to ensure public awareness and to preserve a compelling governmental interest requiring an early effective date in that the amendment informs the public of the established rate of interest to be paid on unpaid amounts of taxes for the 2012 calendar year. A proposed amendment that covers the same material is published in this issue of the **Missouri Register**. The director has limited the scope of the emergency amendment to the circumstances creating the emergency. The director has followed procedures calculated to assure fairness to all interested persons and parties and has complied with protections extended by the **Missouri** and **United States Constitutions**. This emergency amendment was filed October 24, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

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

*AUTHORITY: section 32.065, RSMo 2000. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 24, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-2.010 Definitions**. The Missouri Consolidated Health Care Plan is deleting sections (6), (8), (9), (11), (13), (16), (19), (21), (22), (24)–(26), (29)–(32), (34), (36), (39), (42), (47), (50), (51), (53), (56)–(59), (62), (63), (65)–(67), (71), (75), (78)–(81), (83)–(86), (88)–(90), (93), (96), (99)–(104), (106), (109)–(111), (113), (114), (122), (123), (126), (127), (129), and (132)–(134); amending sections (1), (3)–(5), (9), (10), (14), (18), (23), (27), (28), (33), (37), (38), (40), (41), (43)–(46), (48), (52), (54), (55), (60), (70), (72), (73), (77), (82), (87), (94), (97), (98), (105), (112), (117), (119), (120), (124), (128), and (131); adding sections (9), (22), (24), (30), (45), (47), (56), (71), (73), and (74); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(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]*.

(3) Administrative appeal. A written request submitted by or on behalf of a member involving *[Missouri Consolidated Health Care Plan (MCHCP)]* **plan-related** administrative issues such as eligibility, effective dates of coverage, **and** plan changes*[, etc]*.

(4) Adverse **benefit** 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.]* **An adverse benefit determination means any of the following:**

**(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;**

**(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or**

**(C) Rescission of coverage after an individual has been covered under the plan.**

(5) Allowable *[expense]* **amount**. *[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 and coinsurance amounts.]* **Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed. See balance billing, section (7).**

*[(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:*

*(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or*

*(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.]*

*[(7)]***(6)** Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

*[(8) Assignment. When a doctor agrees to accept Medicare's fee as full payment.]*

*[(9) Benefit period. The three hundred sixty-five (365) days immediately after the first date of services to treat a given condition.]*

**(7) Balance billing. When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars ($100) and the allowed amount is seventy dollars ($70), the provider may bill the member for the remaining thirty dollars ($30). A network provider may not balance bill.**

*[(10)]***(8)** Benefits. *[Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.]* **Health care services covered by the plan.**

*[(11) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.]*

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

*[(13) Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.]*

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

*[(15)]***(11)** Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

*[(16) Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.]*

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

*[(18)]***(13)** Coinsurance. *[The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.]* **The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars ($100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars ($20). The health insurance or plan pays the rest of the allowed amount.**

*[(19) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.]*

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

*[(21) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics."*

*(22) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.]*

*[(23)]***(15)** Copayment. *[A set dollar amount that the covered individual must pay for specific services.]* **A fixed amount, for example, fifteen dollars ($15) the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.**

*[(24) 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.*

*(25) Covered benefits and charges. Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.*

*(26) Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.]*

*[(27)]***(16)** Date of service. Date medical services are received *[or performed]*.

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

*[(29) Dependent child. Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:*

*(A) Stepchild;*

*(B) Foster child;*

*(C) Grandchild for whom the employee has legal guardianship or legal custody; and*

*(D) Other child for whom the employee is the court-ordered legal guardian.*

*1. Except for a disabled child as described in 22 CSR 10-2.010(89), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six (26)).*

*2. A child who is a dependent child under a guardianship of a minor will continue to be a dependent child when the guardianship ends by operation of law when the child becomes eighteen (18) years of age if such child was an MCHCP member the day before the child becomes eighteen (18) years of age.*

*(30) Dependents. The lawful spouse of the employee, the employee's child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom enrollment has been made and has been accepted for participation in the plan.*

*(31) Diagnostic. Describes a procedure to determine whether a person has a particular illness.*

*(32) 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.]*

*[(33)]***(18)** Disease management. A program offered to *[non-Medicare]* members**, who do not have primary Medicare coverage,** to help manage certain chronic diseases.

*[(34) Disposable supplies. Supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.]*

*[(35)]***(19)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;

(B) Doctor of osteopathy;

(C) Podiatrist;

(D) Optometrist;

(E) Chiropractor;

(F) Psychiatrist;

(G) Psychologist;

(H) Doctor of dental medicine, including dental surgery;

(I) Doctor of dentistry; or

(J) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(36) 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.]*

**(20) Effective date. The date on which coverage takes effect as described in 22 CSR 10-2.020(4).**

*[(37)]***(21)** Eligibility date. **The first day a member is qualified to enroll for coverage** *[A]***a**s described in 22 CSR 10-2.020**(2)**.

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

*[(38)]***(23)** Emergency medical condition. *[A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—*

*(A) Conditions placing a person's health in significant jeopardy;*

*(B) Serious impairment to a bodily function;*

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

*(D) Inadequately controlled pain; or*

*(E) Situations when the health of a pregnant woman or her unborn child are threatened.]* **The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:**

**(A) Placing a person's health in significant jeopardy;**

**(B) Serious impairment to a bodily function;**

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

**(D) Inadequately controlled pain; or**

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

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

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

*[(39) Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.]*

*[(40)]***(24)** Emergency Services. With respect to an emergency medical condition—

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

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

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

*[(42) Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is eligible as a dependent up to the age of twenty-six (26), except as noted in 22 CSR 10-2.020(1)(A)3.]*

*[(43)]***(26)** Employer. The state department or agency that employs the eligible employee *[as defined above]*.

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

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

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

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

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

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

(F) Prescription drugs;

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

(H) Laboratory services—lab and *[x]***X**-ray;

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

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

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

*[(45)]***(29)** Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP)**,** who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.

*[(46)]***(30)** Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below **and that the plan administrator determines, in the exercise of its discretion,** is considered experimental/investigational/unproven and is not eligible for coverage under the plan*[. 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, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

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

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

*[(47) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligibility period is the first thirty-one (31) days from the date of the life event.]*

*[(48)]***(31)** Formulary. A list of **U.S. Food and Drug Administration approved** drugs *[covered]* **and supplies developed** by the pharmacy benefit manager and *[as allowed]* **covered** by the plan administrator.

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

*[(50) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.*

*(51) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2011 State Member Handbook (March 15, 2011) or online at www.mchcp.org. It does not include any later amendments or additions.]*

*[(52)]***(33)** Health assessment (HA). A questionnaire about a member's health and lifestyle habits required for participation in the *[wellness]* **Lifestyle Ladder** program.

*[(53) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.]*

*[(54)]***(34)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay **for** current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. *[HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.]*

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

*[(56) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.*

*(57) Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.*

*(58) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.*

*(59) 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 subsection (59)(A) above, 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.]*

*[(60)]***(36)** Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered *[as any other]* **an** illness.

*[(61)]***(37)** Incident. A definite and separate occurrence of a condition.

*[(62) Infertility. Any medical condition causing the inability or diminished ability to reproduce.*

*(63) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.]*

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

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

*(66) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.*

*(67) Lifestyle Ladder. MCHCP's wellness program.]*

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

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

*[(70)]***(41)** myMCHCP. A secure MCHCP member website that *[includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites]* **allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites**.

*[(71) Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.]*

*[(72)]***(42)** 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 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.

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

**(44) Medicare assignment. When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.**

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

*[(75) Network provider. A physician, hospital, pharmacy, or other health provider that is contracted with the plan or its designee.]*

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

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

*[(77)]***(48)** Non-network *[provider or non-participating provider. A physician, hospital, pharmacy, or other health provider that does not have a contract with the plan or its designee]*. **The facilities, providers, and suppliers the health plan does not contract with to provide health care services.**

*[(78) 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.*

*(79) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients recovering from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations that are recognized under Medicare.*

*(80) 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.*

*(81) 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.]*

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

*[(83) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.*

*(84) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.*

*(85) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.*

*(86) 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; 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.*

*(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.]*

*[(87)]***(50)** Participant. *[Any employee or dependent accepted for membership in the plan.]* **Shall have the same meaning as the term member defined herein. See member, section (45).**

*[(88) Pharmacy benefit manager (PBM). The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.*

*(89) Physically or mentally disabled. A person's inability to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.*

*(90) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.]*

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

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

*[(93) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.]*

*[(94)]***(53)** Plan year. The *[calendar year beginning]* **period of** January 1 through December 31. *[This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.]*

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

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

*[(96) Preventive service. A procedure intended for avoidance or early detection of an illness.]*

*[(97)]***(56)** Primary care physician (PCP). *[A physician (usually a]***A**n internist, family/general practitioner, or pediatrician*[) who has contracted with a medical plan]*.

*[(98)]***(57)** Prior 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. Also known as pre-authorization or pre-notification.]* **A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.**

*[(99) Private duty nursing. Nursing care on a full-time basis in the member's home or home health aides.*

*(100) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.*

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

*(102) Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:*
*(A) Date coverage was or will be terminated;*
*(B) Reason for coverage termination; and*
*(C) List of dependents covered.*

*(103) Prostheses. An artificial extension that replaces a missing part of the body or supplements defective parts.*

*(104) Protected health information (PHI). Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.]*

*[(105)]***(58)** Provider. A physician, hospital, medical agency, specialist, or other duly*[-]* licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010*[(35)]***(19)**. Other providers include but are not limited to:
(A) Audiologist (AUD or PhD);
(B) Certified Addiction Counselor for Substance Abuse (CAC);
(C) Certified Nurse Midwife (CNM)—when acting within the scope of *[their]* **his/her** license in the state in which *[they]* **s/he** practice**s** and performing a service which would be payable under this plan when performed by a physician;
(D) Certified Social Worker or Masters in Social Work (MSW);
**(E) Chiropractor;**
*[(E)]***(F)** Licensed Clinical Social Worker;
*[(F)]***(G)** Licensed Professional Counselor (LPC);
*[(G)]***(H)** Licensed Psychologist (LP);
*[(H)]***(I)** Nurse Practitioner (NP);
*[(I)]***(J)** Physician*[s]* Assistant (PA);
*[(J)]***(K)** *[Qualified]* Occupational Therapist;
*[(K)]***(L)** *[Qualified]* Physical Therapist;
*[(L)]***(M)** *[Qualified]* Speech Therapist;
*[(M)]***(N)** Registered Nurse Anesthetist (CRNA);
*[(N)]***(O)** Registered Nurse Practitioner (ARNP); or
*[(O)]***(P)** Therapist with a PhD or Master's Degree in Psychiatry or related field.

*[(106) Provider directory. A listing of network providers within a health plan.]*

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

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

*[(109) 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.*

*(110) Refractions. A record of the patient's preference for the focusing of the eyes that may then be used to purchase eyeglasses or contact lenses. It is the part of the exam that determines what prescription lens gives the patient the best possible vision.*

*(111) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) 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.]*

*[(112)]***(61)** Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020*[(7)(B)]***(2)(D)** and is currently receiving a monthly retirement benefit from a retirement system listed in such rule.

*[(113) Skilled nursing care. Services that must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.*

*(114) Skilled nursing facility (SNF). A public or private facility licensed and operated according to the law that provides—*

*(A) Permanent and full-time facilities for ten (10) or more resident patients;*

*(B) A registered nurse or physician on full-time duty in charge of patient care;*

*(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;*

*(D) A daily medical record for each patient;*

*(E) Transfer arrangements with a hospital; and*

*(F) A utilization review plan.*

*The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.]*

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

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

*[(117)]***(64)** Specialty medications. High cost drugs that *[are primarily self-injectible; sometimes oral medications]* **treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis**.

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

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

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

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

*[(122) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.*

*(123) Surgery center (ambulatory). A hospital-based, hospital-sponsored, or independently-owned facility that performs surgery.]*

*[(124)]***(69)** Survivor. A member who meets the requirements of subsection 22 CSR 10-2.020*[(7)(A)]***(2)(D)**.

**(70) Terminated vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020(2)(D).**

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

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

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

*[(126) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.*

*(127) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.]*

*[(128)]***(74)** Usual, *[C]***c**ustomary, and *[R]***r**easonable *[charge]*. **The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.**

*[(A) Usual. The fee a provider 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 providers 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 providers for ninety percent (90%) of the procedures reported.*

*(129) 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.]*

*[(130)]***(75)** Vendor. The current applicable third-party administrators of MCHCP benefits.

*[(131)]***(76)** Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020*[(7)(B)]***(2)(D)**.

*[(132) Wellness participation year. Year in which members may participate in the wellness program per plan year: October 1–September 25.*

*(133) Wellness program. A voluntary program focusing on awareness, health education, and behavior change.*

*(134) Wellness premium. The monthly medical premium applied to members who successfully complete all requirements of the Lifestyle Ladder program.]*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY RESCISSION

**22 CSR 10-2.020 General Membership Provisions**. This rule established the policy of the board of trustees in regard to the General Membership Provisions of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify general membership provisions.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rescission is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY RULE

**22 CSR 10-2.020 General Membership Provisions**

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

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the*

***Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

(2) Eligibility Requirements.

(A) Employee Eligibility Requirements.

1. An employee may enroll in one (1) of MCHCP's plans if s/he meets the following criteria:

A. A state employee whose position is covered by the Missouri State Employees' Retirement System (MOSERS) and not covered under another retirement or benefit plan supported by state contributions or a member of the Public School Retirement System (PSRS) and employed by a state agency.

2. An employee cannot be covered as an employee and as a dependent.

(B) Dependent Eligibility Requirements.

1. An employee who is not retired may enroll eligible dependents as long as the employee is also enrolled. Eligible dependents include:

A. Spouse.

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

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

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

(IV) If one spouse is a state employee with MCHCP benefits and the other is a public entity employee with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one employer's plan. The spouses cannot have coverage in both places; and

B. Children.

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

(a) Natural child of subscriber or spouse;

(b) Legally adopted child of subscriber or spouse;

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

(d) Stepchild of subscriber or spouse;

(e) Foster child of subscriber or spouse;

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

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

(h) Newborn of a subscriber or a covered dependent;

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

(j) Child who is twenty-six (26) or older and is permanently disabled in accordance with subsection (5)(C), only if such child was an MCHCP member the day before the child turned twenty-six (26).

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

(III) A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time.

(C) Changes in Dependent Status. If a covered dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days to terminate his/her coverage effective the end of the month eligibility ceases.

(D) Retiree, Survivor, Vested, Terminated Vested, and Long-Term Disability Employee; Elected State Officials and their Employee; and Dependent Eligibility Requirements.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is eligible to receive a monthly retirement benefit from either MOSERS or from PSRS for state employment.

A. To enroll or continue coverage at retirement, the employee and his/her dependents must provide all of the following:

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

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

(III) Submit proof of prior coverage and proof of eligibility for dependents if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had other insurance coverage for six (6) months immediately prior to his/her retirement; and

(IV) Submit a statement from PSRS that indicates the effective date of the subscriber's retirement if the subscriber is a PSRS retiree.

B. Employees may continue coverage on their eligible dependents into retirement.

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

2. An enrolled terminated vested or long-term disability employee and his/her dependents will have continuous coverage into retirement unless the member submits a termination form.

3. A survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits and his/her dependents from MOSERS or PSRS may continue coverage if the survivor had—

A. Coverage through MCHCP at the time of the subscriber's death; or

B. Other health insurance for the six (6) months immediately prior to employee's death. Proof of eligibility for each dependent, proof of prior group coverage (letter from previous insurance carrier

or former employer with dates of effective coverage), and a list of dependents covered is required.

4. A survivor of a retired employee or long-term disability recipient may continue coverage if the survivor was covered at the time of the employee's death.

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

A. If a vested employee's spouse is a state employee (active or retired), the vested employee may transfer coverage under the plan in which his/her spouse is enrolled.

B. The employee and his/her dependents must meet one (1) of the following requirements to participate in an MCHCP plan as a terminated vested employee:

(I) Coverage through MCHCP since the effective date of the last open enrollment period; or

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

6. If a vested employee does not elect coverage, or if s/he cancels his/her coverage or dependent coverage, the vested employee and his/her dependents cannot enroll at a later date. The vested employee may continue coverage under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA).

7. If any retired, survivor, terminated vested, or long-term disability employee, or his/her dependents who are 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 except as noted in paragraph (2)(D)8.

8. A long-term disability employee must be eligible for long-term disability benefits from MOSERS or PSRS and have had coverage since the effective date of the last open enrollment period.

A. The employee may continue coverage on his/her dependents or add new dependents due to a life event.

B. If the employee becomes ineligible for disability benefits, the employee and his/her dependents may continue coverage as applicable, as a terminated vested, retired, or COBRA subscriber, unless the employee returns to active state employment.

C. If coverage was not elected through MCHCP before the date of disability, the employee and his/her dependents may enroll as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's disability. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and a list of dependents covered is required.

D. If coverage was not maintained while on disability, the employee and his/her dependents may enroll on the date the employee is eligible for retirement benefits as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's retirement. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and a list of dependents covered is required.

E. If the employee's spouse is a state employee (active or retired), s/he may transfer coverage under the plan in which his/her spouse is enrolled.

F. If the employee wishes to be covered individually at a later date, s/he can make the change, as long as coverage is continuous.

G. If the employee returns to work, the employee and his/her state employee spouse must be covered individually.

9. A retiree, survivor, vested employee, or long-term disability employee and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

10. An elected state official or his/her employees may continue coverage in an MCHCP plan if s/he is a member of the General Assembly, a state official holding a statewide office, or employed by a member of the General Assembly or a state official and his/her employment terminates because the state official or member of the General Assembly ceases to hold elected office. The elected state official or his/her employees must elect to continue coverage within thirty-one (31) days from the last day of the month in which his/her employment is terminated. The member will not later be eligible if s/he discontinues coverage at some future time.

(E) Retiree Returns to State Employment. A retiree who returns to state employment will become eligible for benefits through MCHCP and will be treated as a new employee. The employee is eligible to enroll in medical, dental, or vision coverage with any coverage level within the first thirty-one (31) days of his/her hire date.

(3) Enrollment Procedures.

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

(B) Open Enrollment.

1. An employee may elect coverage and/or change coverage levels during the annual open enrollment period if one (1) of the following occurred:

A. Waived his/her right to insurance when first eligible;

B. Did not enroll eligible dependents when first eligible; or

C. Dropped his/her or dependent coverage during the year.

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

(C) Special Enrollment Periods.

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

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. A retiree, terminated vested, long-term disability, or survivor may apply for dependent coverage if one (1) of the following occurs:

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. MO HealthNet or Medicaid status loss. If an employee who is not retired, terminated, vested, long-term disability, survivor, or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss.

4. Qualified Medical Child Support Order. If a subscriber receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

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

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

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

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

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

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

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her dependent's coverage begins on the first day of the month after enrollment through SEBES.

2. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. The effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP, except for newborns.

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

A. If enrollment by an employee is made before a wedding date, spouse's coverage becomes effective on the wedding date. The monthly premium is not prorated;

B. If enrollment by an employee is made within thirty-one (31) days of a wedding date, spouse's coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

C. If enrollment by a subscriber is made for a newborn of a member, the effective date for the newborn is the birth date. If enrollment is made by an employee due to the birth of a newborn of the employee, the effective date for the employee and newborn is the first of the month coinciding with or after enrollment is received;

D. If enrollment by an employee is made within thirty-one (31) days after the eligibility date, for an adoption, or placement of adopted children, coverage becomes effective on the eligibility date or the first day of the calendar month coinciding with or after the date the enrollment is received; or

E. If enrollment by an employee is made due to legal guardianship of a dependent within thirty-one (31) days of guardianship effective date, the effective date for the dependent is the first day of the calendar month coinciding with or after the date the enrollment is received.

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

5. An employee who transferred from a state department with coverage under another medical care plan into a state department covered by this plan, and his/her eligible dependent(s) who were covered by the other medical plan, will have coverage effective immediately if an enrollment form is submitted within thirty-one (31) days of transfer.

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

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

B. If the employee requests coverage within the first thirty-one (31) days of hire date to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee cancels coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January.

7. An employee and his/her eligible dependent(s) who transfers from another state agency with MCHCP benefits to an MCHCP state agency will be transferred by the former state agency's human resource or payroll representative through eMCHCP to the new state agency. The employee must inform the former agency of the transfer in lieu of a termination. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

8. A Qualified Medical Child Support Order is effective the first of the month coinciding with or after the form is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents. Enrollment of a dependent is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, a letter will be sent requesting it. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or eligible dependent(s) will not be added. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will terminate or never take effect. If enrolling dependents during open enrollment, proof of eligibility must be received by November 20, or eligible dependents will not be added for coverage effective the following January 1.

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

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period; and

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

received, coverage will terminate on day ninety-one (91) from the birth date;

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

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

(B) The employee is required to notify MCHCP on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number.

(C) Permanently disabled children will continue to be eligible beyond age twenty-six (26) during the continuance of a permanent disability, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday:

1. The Supplemental Security Income (SSI) Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

2. A letter from the dependent's physician describing the disability and verifying that the disability predates the SSA determination; and

3. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

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

(6) Military Leave.

(A) Military Leave for an Employee who is not Retired.

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

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for COBRA coverage. The agency payroll representative must notify MCHCP of the effective date of military leave.

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

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

5. The former employee must submit a form within thirty-one (31) days of the employee's return to work for the same level of coverage with the same plan to be reinstated. The former employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work.

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

(B) Military Leave for a Retired Member.

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

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

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

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

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

(7) Termination.

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

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

2. Entry into the armed forces of any country as defined in section (6);

3. With respect to employees, termination of coverage shall occur upon termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule. Termination of employee's coverage shall terminate the coverage of dependents, except as specified in subsection (2)(D);

4. With respect to dependents, termination of coverage shall occur upon divorce or legal separation from the subscriber; or when a child reaches age twenty-six (26). A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. Subscriber shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter. A subscriber cannot cancel coverage on his/her spouse or children during divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce.

B. When a subscriber drops dependent coverage after a divorce, he/she must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or, if requested, the last day of the month in which the divorce was final;

5. Death of dependent. The dependent's coverage ends on the date of death. The subscriber must submit completed form and a copy of the death certificate within thirty-one (31) days of death;

6. Termination due to a member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

7. Termination due to a member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP;

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

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

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

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP, unless the subscriber notifies MCHCP on the first calendar day of the month; then cancellation of coverage is effective the last day of the previous month.

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

(B) A subscriber may retroactively cancel coverage on his/her spouse to be effective on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request.

(C) If a member receives covered services after the voluntary cancellation of coverage, MCHCP may recover the contracted charges

for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

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

1. Upon retirement; or
2. When beginning a leave of absence.

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an 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 MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, form, and bill from MCHCP to continue coverage. If the completed form and payment are returned within ten (10) days of receipt, coverage will continue and the employee will be set up on direct bill.

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

3. If the employee fails to pay the premium due, coverage on the employee and his/her dependents terminates.

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

5. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage in MCHCP while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. For coverage to be reinstated, the employee must submit a completed form within thirty-one (31) days. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and requests reinstatement of coverage.

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

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

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

2. If the employee cancels coverage, coverage ends on the last day of the month.

3. If the employee cancels coverage, the employee must submit a completed form within thirty-one (31) days of his/her return to work.

4. If the employee is unable to return to work after his/her FMLA leave ends, s/he may elect leave of absence coverage or suspend his/her coverage. If coverage is suspended at that time, s/he can enroll within thirty-one (31) days of his/her return to work.

(C) 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. The employee will receive a letter, enrollment form, and bill (if applicable) from MCHCP. If the employee chooses to continue coverage, s/he must return the enrollment form to MCHCP within ten (10) days. If the employee fails to pay the premium due, coverage on the employee and his/her dependents terminates. If the employee's spouse is a state employee (active or retired), the employee may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. If the employee returns to work with an agency covered by MCHCP, the employee and his/her spouse must be covered individually. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If coverage terminates and the employee is recalled to service, eligibility will be as a new employee.

(D) Workers' Compensation.

1. Coverage will automatically be extended to any subscriber who is receiving workers' compensation benefits. Coverage in the plan will be at the same level of coverage (employee only or employee and dependents) and the member must continue to pay the premiums that were previously deducted from his/her paycheck.

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

3. If the subscriber is no longer eligible for workers' compensation benefits but cannot return to work, the subscriber's status changes to leave of absence.

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

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

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

3. If the employee does not continue coverage, s/he will be considered a new hire and may enroll in the plan of his/her choice; or

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

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

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

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

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, eligible dependents can be added to the subscriber's plan upon notification to MCHCP. The subscriber may also add eligible dependents during open enrollment.

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

4. 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.

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

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

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

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

(B) Premium Payments.

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

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

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

(C) Required Notifications.

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

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

(D) Election Periods.

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

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

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

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

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

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

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

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

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

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

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

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

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

(B) If continuation coverage is not chosen within the proper time frames listed below, continuation of coverage ends—

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

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

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

A. A form for election to continue the coverage;

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

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

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

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

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

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

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

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

(12) Medicare.

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

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

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

(13) Communications to Members.

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

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

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

(D) Failure to update a mailing or email address may result in

undeliverable mail/email of important informational material, delayed or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

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

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission and rule covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-2.030 Contributions**. The Missouri Consolidated Health Care Plan is amending sections (1) and (2); adding sections (3)–(5); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the contributions made to the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

(2) The **employee's** contribution *[by the employee]* **toward total premium** shall be determined by the plan administrator *[for state employees]*.

**(3) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium is based on creditable years of service at retirement with the state. It is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%). After the percentage is computed, the percentage is multiplied by the PPO 600 Plan total premium for non-Medicare retirees, the percentage is multiplied by the PPO 600 Plan total premium reduced by both the tobacco-free incentive and the wellness incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.**

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

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

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

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

**A. If past premiums are owed due to timing of the receipt of the form, timing of the receipt of proof of eligibility or other circumstances, premium payroll deductions due are divided and taken in up to three (3) of the employees' future payrolls and/or additional payrolls at the discretion of MCHCP.**

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

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

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

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

**C. If premiums are owed due to timing of the receipt of the change, the agency collects the premiums owed and includes the premium with the monthly deductions submitted the next month.**

**(C) Retirees and Survivors Premiums From Benefit Check.**

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

**check deduction is taken for October medical, dental, and vision premiums).**

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

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

**2. If a member is in arrears for two (2) months of premiums and payment is not received by the fifteenth of the second month for which premiums are due, coverage is terminated due to nonpayment on the last day of the month for which full premium was received. The member will be responsible for the value of the services rendered after the retroactive termination date (example: bill sent September 30 for October premiums and no payment received; bill mailed October 31 for October and November premiums due on November 15. If payment is not received, coverage will be terminated due to nonpayment effective September 30).**

**(E) ACH Electronic Payment of Premiums for COBRA, Long-term Disability, Terminated Vested, Retiree, and Survivor Members.**

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

**2. If there are insufficient funds, MCHCP will send the member a letter and bill requesting payment. If a payment is in arrears, the direct bill timeline applies as defined in paragraph (4)(D)2.**

**(5) Premium Payments.**

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

**(B) A retiree or survivor has a choice to have the premium deducted from his/her retirement check or survivor's benefit check, automatically withdrawn from the retiree's or survivor's bank account, or may receive a monthly bill from MCHCP.**

**1. If the retirement check or survivor's benefit check is not sufficient to cover the premium, the retiree's or survivor's contribution toward total premium, the contribution may be either automatically withdrawn from the retiree's or survivor's bank account, or the retiree or survivor may elect to receive a monthly bill.**

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

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

**(C) If a member fails to pay premiums on the required due date, MCHCP allows a thirty-one (31)-day grace period. In the event that MCHCP has not received payment of premium at the end of the thirty-one (31)-day grace period, the member will be retroactively terminated to the date covered by the member's last paid premium. The member will be responsible for the value of the services rendered after the retroactive termination date, including, but not limited to, the grace period.**

*[(3)]***(6)** 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. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

## EMERGENCY AMENDMENT

**22 CSR 10-2.045 Plan Utilization Review Policy**. The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan Medical Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

(A) Prior *[a]***A**uthorization of *[s]***S**ervices—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. *[Participants]* **Members** who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent

omission about the person's health condition or the cause of the condition will not be covered.

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

A. Ambulance services for non-emergen*[cy]***t** use whether air or ground;

**B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;**

*[B.]***C.** Applied behavior*[al]* analysis for autism;

**D. Auditory brainstem implant (ABI);**

**E. Bariatric procedures;**

*[C.]***F.** Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;

*[D.]***G.** Chiropractic services after twenty-six (26) visits annually;

*[E]***H.** Cochlear implant device;

**I. Chelation therapy;**

*[F.]***J.** Dental care to reduce trauma and restorative services when the result of accidental injury;

*[G.]***K.** Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

*[H.]***L.** Genetic testing or counseling;

*[I.]***M.** Home health care and palliative services;

*[J.]***N.** Hospice care;

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

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

*[M.]***Q.** Nutritional counseling after three (3) sessions annually;

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

*[O. Oxygen provided on an outpatient basis;]*

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

**T. Procedures with codes ending in "T";**

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

*[R.]***V.** Skilled nursing facility;

*[S.]***W.** Surgery (outpatient)—The following outpatient surgical procedures: **cornea transplant,** potential cosmetic surgery, sleep apnea surgery, implantable stimulators, **stimulators for bone growth,** surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); *[surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitus; incision of accessory sinuses, salivary glands, or ducts; or frenectomy);]* and

*[T.]***X.** Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications*[. Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider]*;

C. Medications that may be prescribed for several conditions**,** including some *[where]* **for which** treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of the inpatient admission to certify the necessity of the continued stay in the hospital. *[Participants]* **Members** who have another primary carrier, including Medicare, are not subject to this provision; and

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

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is amending sections (1)–(3); adding sections (4)–(7); and renumbering as necessary.

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

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

*[(C) Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.]*

*[(D)]***(C)** During a hospital admission for delivery, only the **covered** mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

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

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

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

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

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

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

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

*[(A)]***(C)** Network out-of-pocket maximum for individual—one thousand two hundred dollars ($1,200).

*[(B)]***(D)** Network out-of-pocket maximum for family—two thousand four hundred dollars ($2,400).

*[(C)]***(E)** Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

*[(D)]***(F)** Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

*[(E)]***(G)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the *[U]***u**sual, *[C]***c**ustomary, and *[R]***r**easonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

**(4) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all claim and payment information of the family unit. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.**

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

**(6) Copayments—set charges for the following services apply as long as network providers are utilized. Copayments do not apply to the deductible or out-of-pocket maximum.**

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

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

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

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

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

*[(4)]***(8)** 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. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

## EMERGENCY AMENDMENT

**22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is amending sections (1)–(3); adding sections (4)–(6); and renumbering as necessary.

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

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars ($600); family *[limit]* each calendar year, one thousand two hundred dollars ($1,200). Non-network: per individual each calendar year, one thousand two hundred dollars ($1,200); family *[limit]* each calendar year, two thousand four hundred dollars ($2,400).

*[(C) Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees. ]*

*[(D)]***(C)** During a hospital admission for delivery, only the **covered** mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

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

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

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

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

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

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

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

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

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

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

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

*[(E)]***(G)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the *[U]***u**sual, *[C]***c**ustomary, and *[R]***r**easonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a

non-network provider.

**(4) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all claim and payment information of the family unit. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.**

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

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

*[(4)]***(7)** 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. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

## EMERGENCY AMENDMENT

**22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is deleting section (5); amending sections (1)–(3) and (6); adding sections (4), (8), and (9); and renumbering as necessary.

*PURPOSE: This amendment changes 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.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Deductible amount—Network: per individual 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 each calendar year, two thousand four hundred dollars ($2,400); family *[limit]* each calendar year, four thousand eight hundred dollars ($4,800).

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

*[(A)]***(B)** The family deductible *[must be met before claim payments begin, applicable when two (2) or more family members are covered]* **applies when two (2) or more family members are covered**. **The family deductible must be met before claim payment begins for any covered member.**

*[(B) If both a husband and wife are state employees covered by Missouri Consolidated Health Care Plan (MCHCP) and they both enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), they must each have a separate HSA. The maximum contribution MCHCP will make for the family is one thousand four hundred dollars ($1,400) regardless of the number of HSAs or the number of children covered under the HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a seven-hundred-dollar ($700) contribution to each spouse, to total one thousand four hundred dollars ($1,400).*

*(C) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.]*

*[(D)]***(C)** During a hospital admission for delivery, only the **covered** mother's claims will be subject to deductible and *[coinsurance]* **out-of-pocket maximum**. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

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

the calendar year once the out-of-pocket maximum is reached.

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

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

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

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

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

**(B) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before claim payment begins for any covered member.**

*[(A)]***(C)** Network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

*[(B)]***(D)** Network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

*[(C)]***(E)** Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars ($4,800).

*[(D)]***(F)** Non-network out-of-pocket maximum for family—nine thousand six hundred dollars ($9,600).

*[(E)]***(G)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the *[U]***u**sual, *[C]***c**ustomary, and *[R]***r**easonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

**(4) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all claim and payment information of the family unit. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.**

*[(4)]***(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.

*[(5) Pharmacy benefits are subject to the HDHP deductible and coinsurance.]*

(6) A member does not qualify for the HDHP if *[they are]* **s/he is** covered under or enrolled in any of the following types of insurance plans or programs:

(E) The *[participant]* **member** has veteran's benefits that have been used within the past three (3) months.

**(8) Health Savings Account (HSA) Contributions.**

**(A) To receive contributions from MCHCP, the employee must open a HSA with the bank designated by MCHCP.**

**(B) MCHCP will make a twenty-five dollar ($25) monthly contribution to the employee's HSA account to total three hundred dollars ($300) annually. If a family is enrolled, MCHCP will make a fifty dollar ($50) contribution to the employee's HSA account to total six hundred dollars ($600) annually.**

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

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

*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. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY RESCISSION

**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges**. This rule established the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rescission is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the*

*Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

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

## EMERGENCY RULE

### 22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges

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

*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.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

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

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

1. Prescribed by an appropriate health care provider for the therapeutic treatment of injury or sickness;

2. To the extent they do not exceed any limitation or exclusion; and

3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided, 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, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A physician visit to seek a second opinion is a covered service.

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

(E) Medical plan benefits, limitations, and exclusions effective January 1, 2012, are incorporated by reference into this rule and are available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, or online at www.mchcp.org. This rule does not include any later amendments or additions.

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

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically significant allergic symptoms. 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;

2. Ambulance service. Ambulance transport services involve the use of specially designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of

environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty thousand dollar ($40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically-necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

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

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

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

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

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

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

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

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

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

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

19. Hair prostheses. Prostheses and expenses for scalp hair

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

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

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

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

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

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

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

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

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

24. Hospital (includes inpatient, outpatient and surgical centers). The following benefits are covered:

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

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(III) A state-licensed psychologist;

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

(V) Licensed professional counselor;

25. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two (2)-visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender

and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider;

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets-covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

32. Preventive services.

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

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

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

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

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One exam (1) per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings:

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

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

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

(IV) Colorectal Screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive regardless of diagnosis. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza). The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out-of-network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically necessary preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related;

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

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

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

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

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ($VO_2$max) equal to or less than twenty milliliter per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

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

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic

Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation: direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

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

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

(III) Meals—not covered.

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

(I) Allogenic bone marrow—one hundred forty three thousand dollars ($143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars ($121,000);

(III) Heart—one hundred twenty-eight thousand dollars ($128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars ($133,000);

(V) Lung—one hundred fifty-one thousand dollars ($151,000);

(VI) Kidney—Fifty-four thousand dollars ($54,000);

(VII) Kidney and Pancreas—ninety-seven thousand dollars ($97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars ($153,000).

38. Urgent care. Services to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the* ***Code of State Regulations****. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission and rule covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY AMENDMENT

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

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

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

*[(1)]***(2)** Claims Submissions and Initial Benefit Determinations.

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

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

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

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must

notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

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

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

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

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

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

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

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based**,** with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

*[(2)]***(3)** General Appeal Provisions.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave *[rights]* **rise** to the appeal.

*[(3)]***(4)** Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage *[once]* **after** an individual has been covered under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical *[and pharmacy]* benefits administered by *[plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc.,]* **Coventry Health Care** in accordance with state law and regulations promulgated by DIFP *[and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010]*. **The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR and Express Scripts Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).**

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the *[DIFP]* external

review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review *[by DIFP]* **except as specifically provided in 22 CSR 10-2.075(4)(A)4**.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 8086
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through *[Mercy Health Plans]* **Coventry Health Care**—

(a) First and second level appeals must be submitted in writing to—

*[Mercy Health Plans*
*Attn: Corporate Appeals*
*14528 S. Outer 40 Road, Suite 300*
*Chesterfield, MO 63017]*
**Coventry Health Care**
**Attn: Appeals Department**
**550 Maryville Centre, Ste. 300**
**St. Louis, MO 63141**

(b) Expedited appeals must be communicated by calling *[Mercy Health Plans]* **Coventry Health Care** telephone *[1-800-830-1918, ext. 2394]* **1-314-214-2394** or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
*[Clinical Appeals—MH3*
*6625 West 78th Street, BL0390]*

**Attn: Pharmacy Appeals—MH3**
**Mail Route 0390**
**6625 W. 78th St.**
Bloomington, MN 55439
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

**(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.**

**(II) The claimant can submit an external review request in writing to—**

**Office of Consumer Information and Oversight**
**Department of Health and Human Services**
**PO Box 791**
**Washington DC 20044**
**or by fax to 1-202-606-0036**
**or by email to disputedclaim@opm.gov**

**(III) The claimant may call the toll-free number 1-877-549-8152 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.**

**(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.**

**(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.**

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

*[(4)]***(5)** Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

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

*[(5)]***(6)** In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.

(A) 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) Agency error—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, *[the]* MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. **Plan changes are effective February 1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Wellness Program]* **Lifestyle Ladder** participation—MCHCP may deny all appeals regarding continuation of participation in the *[Wellness]* **Lifestyle Ladder** Program due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-2.090 Pharmacy Benefit Summary**. The Missouri Consolidated Health Care Plan is deleting sections (2), (4), and (8); amending the purpose, sections (1), (5), and (7); adding sections (6)–(8); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300 Plan, PPO 600 Plan, HDHP with HSA, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300, PPO 600, **HDHP with HSA,** and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) The pharmacy benefit provides coverage for prescription drugs**.** *[listed on the formulary, as described in the following:]* **Vitamins and nutrients coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.**

(A) *[Medications.]* **PPO 300, PPO 600, and Medicare Supplement Plan Prescription Drug Coverage.**

1. Retail—Network:

A. Generic: Eight-dollar ($8) copayment for up to a thirty (30)-day supply for **a** generic drug on the formulary**; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**;

B. Brand: Thirty-five-dollar ($35) copayment for up to a thirty (30)-day supply for **a** brand drug on the formulary**; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**;

**C. Non-formulary: One hundred dollar ($100) copayment for up to a thirty (30)-day supply for a drug not on the formulary;**

*[C.]***D.** *[Mail order]* **Home delivery** program—

(I) *[Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for a twenty-dollar ($20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent ($87.50) copayment for a brand drug on the formulary.]* **Maintenance prescriptions may be filled through the home delivery program. Some medications may not qualify for the program because they require prior authorization or quantity level limits.**

**(a) Generic: Twenty dollar ($20) copayment for up to a ninety (90)-day supply for a generic drug on the formulary.**

**(b) Brand: Eighty-seven dollars and fifty cent ($87.50) copayment for up to a ninety (90)-day supply for a brand drug on the formulary.**

**(c) Non-formulary: Two hundred fifty dollar ($250) copayment for up to a ninety (90)-day supply for a drug not on the formulary; and**

(II) Specialty drugs covered only through network *[mail order]* **home delivery** for up to thirty (30) days. *[Copayments—]* **The first specialty prescription order may be filled through a retail pharmacy.**

(a) Generic: *[e]***E**ight dollars ($8) for generic drug on the formulary list*[; and]***.**

(b) Brand: *[t]***T**hirty-five dollars ($35) for brand drug on the formulary.

**(c) Non-formulary: One hundred dollar ($100) copayment for a drug not on the formulary;**

**E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;**

**F. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment;**

**G. If the physician allows for generic substitution and the member chooses a brand name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and**

**H. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary.**

2. *[Non-network pharmacies]* **Retail—Non-network:***[—]* If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. *[S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment or coinsurance. All such claims must be filed within twelve (12) months of the incurred expense.]* **The pharmacy plan administrator will reimburse the cost of the drug based on the network discounted amount, less the applicable copayment.**

**A. Generic: Eight dollar ($8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary.**

**B. Brand: Thirty-five dollar ($35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary.**

**C. Non-formulary: One hundred dollar ($100) copayment for up to a thirty (30)-day supply for a drug not on the formulary.**

*[3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single*

*dosage amount.]*

**(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.**

**1. Retail—Network:**

**A. Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; tobacco cessation prescriptions covered at one hundred percent (100%);**

**B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; tobacco cessation prescriptions covered at one hundred percent (100%);**

**C. Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary;**

**D. Home delivery program.**

**(I) Maintenance prescriptions may be filled through the home delivery program. Some medications may not qualify for the program because they require prior authorization or quantity level limits.**

**(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.**

**(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.**

**(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary.**

**(II) Specialty drugs covered only through network home delivery for up to thirty (30) days.**

**(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.**

**(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.**

**(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary; and**

**E. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.**

**2. Retail—Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. The pharmacy plan administrator will reimburse the cost of the drug based on the network discounted amount, less the applicable deductible or coinsurance.**

**A. Generic: Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a generic drug on the formulary.**

**B. Brand: Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a brand drug on the formulary.**

**C. Non-formulary: Fifty percent (50%) coinsurance after deductible for up to a thirty (30)-day supply for a drug not on the formulary.**

*[(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.]*

*[(3)]***(2)** Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

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

*[(4) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.]*

*[(5)]***(3)** Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; *[and]*

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include:

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply*[.]***; and**

**(C) Members must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted price as determined by the vendor minus any applicable copayment. Members are responsible for any charge over the network discounted price and the applicable copayment.**

*[(6)]***(4)** Formulary—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or

(C) A drug is determined to have a safety issue.

*[(7)]***(5)** *[Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug.]* **Grandfathered Specialty Drugs—Prescription drugs grandfathered for members in 2011 because they had taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011, will continue to be covered at a thirty-five dollar ($35) brand copayment level if enrolled in a PPO plan or at twenty percent (20%) coinsurance if enrolled in the HDHP plan.** Grandfathered drugs include:

(A) Alzheimer's disease drugs;
(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);
(C) Anti-epileptics;
**(D) Attention-deficit hyperactivity disorder (ADHD);**
*[(D)]***(E)** Biologics for inflammatory conditions;
*[(E)]***(F)** Cancer drugs;
*[(F)]***(G)** Hemophilia drugs (*[F]***f**actor VIII and IX concentrates);
*[(G)]***(H)** Hepatitis drugs;
*[(H)]***(I)** Immunosuppressants (transplant anti-rejection agents);
*[(I)]***(J)** Insulin (basal);
*[(J)]***(K)** Low molecular weight heparins;
*[(K)]***(L)** Multiple sclerosis injectable drugs;
*[(L)]***(M)** Novel psychotropics (oral products and long-active injectables);
*[(M)]***(N)** Phosphate binders;
*[(N)]***(O)** Pulmonary hypertention drugs; and
*[(O)]***(P)** Somatostatin analogs.

*[(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.]*

**(6) Medicare Part B Prescription Drugs—For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:**
**(A) Diabetes testing and maintenance supplies;**
**(B) Respiratory agents;**
**(C) Immunosuppressants; and**
**(D) Oral anti-cancer medications.**

**(7) Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the Food and Drug Administration and medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.**

**(8) Guidelines for Drug Use—If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

## EMERGENCY AMENDMENT

**22 CSR 10-2.091 Wellness Program Coverage, Provisions, and Limitations**. The Missouri Consolidated Health Care Plan is amending sections (1)–(4).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the wellness program.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by November 25, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective November 25, 2011, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective November 25, 2011, and expires May 22, 2012.*

(1) Eligibility—*[All non-Medicare primary active, retiree, terminated vested, long term disability (LTD), survivor, and Consolidated Omnibus Budget Reconciliation Act (COBRA) subscribers and their non-Medicare primary spouses enrolled in a Missouri Consolidated Health Care Plan (MCHCP) medical plan may participate in the wellness program.]* **All Missouri Consolidated Health Care Plan (MCHCP) subscribers and covered spouses who do not have the TRICARE Supplement Plan or Medicare as primary coverage are eligible.** Each eligible member must participate separately.

(A) *[Members]* **Eligible members** may begin participating on or after their eligibility date or during the open enrollment (OE) period.

(2) Limitations and Exclusions.

**(C) Dependent children who are covered under a parent's plan and who are also state employees are not eligible to participate.**

*[(C)]***(D)** Members must have a Social Security number on file with MCHCP to be eligible to participate.

*[(D)]***(E)** When Medicare becomes a subscriber's primary insurance payer, the subscriber and participating spouse are no longer eligible to participate and will lose the wellness premium.

*[(E)]***(F)** When Medicare becomes a spouse's primary insurance payer, the spouse is no longer eligible to participate and will lose the wellness premium. The non-Medicare subscriber may continue to participate in the program.

(3) Participation. Members earn points through successful completion of activities as specified in the wellness program web portal through myMCHCP.

(A) The wellness program is *[voluntary]* **called Lifestyle Ladder**.

**(B) The Lifestyle Ladder program is voluntary.**

*[(B)]***(C)** Members are responsible for enrolling, participating, and completing activities, as well as keeping track of their applicable deadlines and points.

*[(C)]***(D)** Each activity has different enrollment, participation, and completion criteria.

1. Some activities require use of the Internet and/or a unique email address.

2. The vendor will make all determinations regarding activity enrollment, participation, and completion.

3. The vendor will award all points upon completion of an activity.

4. Completion of activities outside of the wellness participation period may result in points being applied to the next wellness participation period.

5. Members with disabilities may request special accommodations in writing to the vendor regarding activity participation.

*[(D)]***(E)** The required HA must be completed annually before points begin accruing.

*[(E)]***(F)** Points are assigned by the vendor in the wellness participation period in which they are earned by the participating member.

*[(F)]***(G)** The wellness participation period is the time frame in which activities must be completed in order to earn the wellness premium. The wellness participation periods are as follows: *[October 1–December 25; January 1–March 25; April 1–June 25; and July 1–September 25]* **October 1–November 25; December 1–February 25; March 1–May 25; and June 1–August 25**.

*[(G)]***(H)** The wellness coverage period is the time frame in which members receive the wellness premium for participation. The wellness coverage periods are as follows: January 1–March 31; April 1–June 30; July 1–September 30; and October 1–December 31.

*[(H)]***(I)** MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from the wellness program, loss of the wellness premium, and/or prosecution.

(4) Wellness Premium. Members qualify for the wellness premium as follows:

(B) Points are accumulated in and can be monitored by the participating member from the wellness program web portal accessed through myMCHCP **or by calling the vendor**; **and**

(C) Members reaching the minimum one hundred (100)-point threshold per wellness participation period will receive the wellness premium **(fifteen dollars ($15) off his or her monthly premium)** in the future wellness coverage period.

1. Members earning over one hundred (100) points in a given wellness participation period will receive the wellness premium in the future wellness coverage period, and all points over one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

2. Members not earning at least one hundred (100) points in a given wellness participation period will not receive the wellness premium for the future wellness coverage period, but the points earned totaling less than one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

3. A maximum of four hundred (400) points per wellness participation year is possible.

4. All earned points zero out at the end of the wellness participation year*[; and]***.**

*[(D) The wellness premium will be applied to subscriber paychecks or retiree benefit checks at the beginning of each wellness coverage period.]*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 20, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Nov. 25, 2011, expires May 22, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

## EMERGENCY RULE

### 22 CSR 10-2.094 Tobacco-Free Incentive Provisions and Limitations

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the tobacco-free incentive benefit.*

*EMERGENCY STATEMENT: This emergency rule must be in place by November 25, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective November 25, 2011, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective November 25, 2011, and expires May 22, 2012.*

(1) Eligibility—All Missouri Consolidated Health Care Plan (MCHCP) subscribers and covered spouses who do not have the TRICARE Supplement Plan or Medicare as primary coverage are eligible. A spouse of a Medicare primary employee who is a retiree, long-term disability (LTD), or survivor may not participate in the tobacco-free incentive regardless of the spouse's Medicare eligibility status. Each eligible member must participate separately.

(A) Eligible members must attest when they become eligible for coverage or during the open enrollment period to receive the incentive.

(B) Eligible members with a break in coverage within the same plan year must complete the tobacco-free attestation by fax or mail.

(2) Limitations and Exclusions.

(A) Dependent children are not eligible to receive the incentive.

(B) Dependent children who are covered under a parent's plan and who are also state employees are not eligible to receive the incentive.

(C) When Medicare becomes a subscriber's primary insurance payer, the subscriber and participating spouse are no longer eligible to receive the incentive.

(D) When Medicare becomes a spouse's primary insurance payer, the spouse is no longer eligible to receive the incentive. The non-Medicare subscriber may continue to receive the incentive.

(3) Incentive Participation Requirement.

(A) To receive the incentive beginning on January 1, 2012, eligible members must do one (1) of the following:

1. Tobacco-free attestation.

A. The member must complete a tobacco-free attestation online through myMCHCP or submit a completed form by fax or mail during the period of October 1, 2011, through November 25, 2011. The form must be received by November 25, 2011; or

2. Tobacco cessation program attestation.

A. Participate in an MCHCP approved tobacco cessation program as defined in section (3) and complete a tobacco cessation program attestation online through myMCHCP or submit a completed form by fax or mail during the period of October 1, 2011, through November 25, 2011. The form must be received by November 25, 2011.

(I) If a subscriber and his/her spouse become and remain tobacco-free three (3) months prior to May 25, 2012, s/he may continue to receive the incentive through December 31, 2012, if s/he completes a tobacco-free attestation through myMCHCP or submit a completed form by fax or mail by May 25, 2012. The form must be received by May 25, 2012.

(B) For a new employee or an employee added during a special enrollment period and his/her spouse to receive the incentive from the employee's effective date of coverage, the employee must complete a tobacco-free attestation or tobacco cessation program attestation at the time of enrollment. A covered spouse's attestation must be completed within thirty-one (31) days of enrollment. If a subscriber and/or his/her spouse complete the tobacco cessation program attestation and become and remain tobacco-free three (3) months prior to May 25, 2012, s/he can continue to receive the incentive through December 31, 2012, if s/he completes a tobacco-free attestation through myMCHCP or submits a completed form by fax or mail by May 25, 2012. A form must be received by May 25, 2012. A new employee and spouse added during a special enrollment period after May 25, 2012, must complete the tobacco-free attestation form to receive the incentive within thirty-one (31) days of enrollment.

(C) A waiver may be granted if a member provides a physician certification that a medical condition prevents the member from achieving tobacco-free status.

(D) Eligible members with a break in coverage within the same plan year must again attest to be tobacco-free through an online attestation or submit a paper attestation form to MCHCP.

(E) If a member attests to be tobacco-free but starts to use tobacco products, he/she must contact MCHCP through myMCHCP or by phone, fax, or mail immediately to change his/her status. MCHCP will adjust his/her premium for coverage beginning the second month after the member self reports.

(F) MCHCP may audit the attestation for accuracy.

(4) MCHCP approved tobacco cessation programs are—

(A) StayWell Tobacco NextSteps: Phone coaching (866-564-5235);

(B) Missouri Tobacco Quitline: 800-QUIT-NOW (800-784-8669); or

(C) American Cancer Society Quit for Life (866-784-8454).

(5) MCHCP may utilize participation data for purposes of offering additional programs in accordance with the MCHCP privacy policy.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Nov. 25, 2011, expires May 22, 2012. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

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

## EMERGENCY RULE

### 22 CSR 10-2.095 TRICARE Supplement Plan

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

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) TRICARE is the Department of Defense's health insurance program for the military community. Primary coverage is through TRICARE with the Missouri Consolidated Health Care Plan TRICARE Supplement Plan paying secondary on claims.

(A) TRICARE Supplement Plan design is defined and provided by the Association and Society Insurance Corporation (ASI).

(B) TRICARE Supplement Plan eligibility, enrollment, and termination requirements are determined by ASI.

(C) Total TRICARE Supplement Plan premium costs for all coverage levels are fully paid by the member and collected by the plan administrator.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

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

## EMERGENCY RULE

**22 CSR 10-2.100 Fully-Insured Medical Plan Provisions**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Fully-Insured Plan Provisions of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

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

## EMERGENCY AMENDMENT

**22 CSR 10-3.010 Definitions**. The Missouri Consolidated Health Care Plan is deleting sections (6), (8), (9), (11), (13), (16), (19), (21), (22), (24)–(26), (29)–(32), (34), (36), (39), (42), (47), (50)–(53), (55)–(58), (61), (62), (64)–(66), (70), (77)–(80), (82)–(85), (87)–(89), (92), (95), (98)–(103), (105), (109)–(111), (113), (114), (122)–(124), (126), (127), (129), and (131); amending sections (1), (3)–(5), (10), (14), (18), (23), (28), (33), (37), (38), (41), (43), (46), (48), (53), (69), (72), (74), (76), (81), (86), (93), (96), (97), (104), (112), (117), and (128); adding sections (7), (20), (22), (28), (43), and (54); and renumbering as necessary.

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

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(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]*.

(3) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, **and** plan changes*[, etc]*.

(4) Adverse **benefit** 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.]* **An adverse benefit determination means any of the following:**

**(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;**

**(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or**

**(C) Rescission of coverage after an individual has been covered under the plan.**

(5) Allowable *[expense]* **amount**. *[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 and coinsurance amounts.]* **Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed. See balance billing, section (7).**

*[(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:*

*(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or*

*(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.]*

*[(7)]***(6)** Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

*[(8) Assignment. When a doctor agrees to accept Medicare's fee as full payment.*

*(9) Benefit period. The three hundred sixty-five (365) days immediately after the first date of the services to treat a given condition.]*

**(7) Balance billing. When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars ($100) and the allowed amount is seventy dollars ($70), the provider may bill the member for the remaining thirty dollars ($30). A network provider may not balance bill.**

*[(10)]***(8)** Benefits. *[Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.]* **Health care services covered by the plan.**

*[(11) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.]*

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

*[(13) Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.]*

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

*[(15)]***(11)** Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

*[(16) Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.]*

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

*[(18)]***(13)** Coinsurance. *[The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.]* **The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars ($100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars ($20). The health insurance or plan pays the rest of the allowed amount.**

*[(19) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.]*

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

*[(21) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics."*

*(22) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.]*

*[(23)]***(15)** Copayment. *[A set dollar amount that the covered individual must pay for specific services.]* **A fixed amount for example, fifteen dollars ($15) the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.**

*[(24) Cosmetic surgery. A procedure performed primarily for psychological purposes or 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.*

*(25) Covered benefits and charges. Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.*

*(26) Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.]*

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

*[(28)]***(17)** 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.]* **The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay.**

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

*[(29) Dependent child. Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:*

*(A) Stepchild;*

*(B) Foster child;*

*(C) Grandchild for whom the employee has legal guardianship or legal custody; and*

*(D) Other child for whom the employee is court-ordered legal guardian.*

*1. Except for a disabled child as described in 22 CSR 10-3.010(88), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26).*

*2. A child who is a dependent child under a guardianship of a minor will continue to be a dependent child when the guardianship ends by operation of law when the child becomes eighteen (18) years of age if such child was an MCHCP member the day before the child becomes eighteen (18) years of age.*

*(30) 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.*

*(31) Diagnostic. Describes a procedure to determine whether a person has a particular illness.*

*(32) 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.]*

*[(33)]***(18)** Disease management. A program offered to *[non-Medicare]* members**, who do not have primary Medicare coverage,** to help manage certain chronic diseases.

*[(34) Disposable supplies. Supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.]*

*[(35)]***(19)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;

(B) Doctor of osteopathy;

(C) Podiatrist;

(D) Optometrist;

(E) Chiropractor;

(F) Psychiatrist;

(G) Psychologist;

(H) Doctor of dental medicine, including dental surgery;

(I) Doctor of dentistry; or

(J) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

*[(36) 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.]*

**(20) Effective date. The date on which coverage takes effect as described in 22 CSR 10-3.020(4).**

*[(37)]***(21)** Eligibility date. **The first day a member is qualified to enroll for coverage** *[A]*as described in 22 CSR 10-3.020**(2)**.

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

*[(38)]***(23)** Emergency medical condition. *[A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—*

*(A) Conditions placing a person's health in significant jeopardy;*

*(B) Serious impairment to a bodily function;*

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

*(D) Inadequately controlled pain; or*

*(E) Situations when the health of a pregnant woman or her unborn child are threatened.]* **The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:**

**(A) Placing a person's health in significant jeopardy;**

**(B) Serious impairment to a bodily function;**

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

**(D) Inadequately controlled pain; or**

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

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

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

*[(39) Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.]*

*[(40)]***(24)** Emergency Services. With respect to an emergency medical condition—

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

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

*[(41)]***(25)** Employee. A **benefit-eligible** person employed by a participating public entity and present and future retirees from the participating public entity who meet the **plan** eligibility requirements *[as prescribed by the participating public entity]*.

*[(42) 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 10-3.030(1)(A)7.]*

*[(43)]***(26)** Employer. The public entity that employs the eligible employee *[as defined above]*.

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

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

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

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

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

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

(F) Prescription drugs;

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

(H) Laboratory services—lab and *[x]***X**-ray;

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

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

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

*[(45)]***(29)** Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.

*[(46)]***(30)** Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below **and that the plan administrator determines, in the exercise of its discretion,** is considered experimental/investigational/unproven and is not eligible for coverage under the plan*[. 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, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

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

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

*[(47) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date of the lift event.]*

*[(48)]***(31)** Formulary. A list of **U.S. Food and Drug Administration approved** drugs *[covered]* **and supplies developed** by the pharmacy benefit manager and *[as allowed]* **covered** by the plan administrator.

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

*[(50) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.*

*(51) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2011 Public Entity Member Handbook (March 15, 2011) or online at www.mchcp.org. It does not include any later amendments or additions.*

*(52) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.]*

*[(53)]***(33)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay **for** current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. *[HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.]*

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

*[(55) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.*

*(56) Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.*

*(57) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying*

*body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.*

*(58) 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 subsection (58)(A) above, 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.]*

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

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

*[(61) Infertility. Any medical condition causing the inability or diminished ability to reproduce.*

*(62) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.]*

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

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

*(65) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.*

*(66) Lifetime. The period of time a member or the member's eligible dependents participate in the plan.]*

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

*[(68)]***(39)** MCHCPid. An individual MCHCP member identifier used for member verification and validation.

*[(69)]***(40)** myMCHCP. A secure MCHCP member website that *[includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites]* **allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites**.

*[(70) Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.]*

*[(71)]***(41)** 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;

(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 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.

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

**(43) Medicare assignment. When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.**

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

*[(74) Network provider. A physician, hospital, pharmacy, or other health provider that is contracted with the plan or its designee.]*

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

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

*[(76)]***(47)** Non-network *[provider or non-participating provider. Any physician, hospital, pharmacy, or other health provider that does not have a contract with the plan or its designee]*. **The facilities, providers, and suppliers the health plan does not contract with to provide health care services.**

*[(77) 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.*

*(78) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients recovering from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations that are recognized under Medicare.*

*(79) 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.*

*(80) 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.]*

*[(81)]***(48)** Out-of-pocket maximum. *[The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.]* **The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.**

*[(82) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.*

*(83) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.*

*(84) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.*

*(85) 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; 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.*

*(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.]*

*[(86)]***(49)** *[Any employee or dependent accepted for membership in the plan.]* Participant. **Shall have the same meaning as the term member defined herein. See member, section (44).**

*[(87) Pharmacy benefit manager (PBM). The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.*

*(88) Physically or mentally disabled. A person's inability to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.*

*(89) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.]*

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

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

*[(92) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.]*

*[(93)]***(52)** Plan year. The *[calendar year beginning]* **period of** January 1 through December 31. *[This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.]*

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

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

*[(95) Preventive service. A procedure intended for avoidance or early detection of an illness.]*

*[(96)]***(55)** Primary care physician (PCP). *[A physician (usually a]***A**n internist, family/general practitioner, or pediatrician*[) who has contracted with a medical plan]*.

*[(97)]***(56)** Prior 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. Also known as pre-authorization or pre-notification.]* **A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.**

*[(98) Private duty nursing. Nursing care on a full-time basis in the member's home or home health aides.*

*(99) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.*

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

*(101) Proof of prior coverage. If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:*

*(A) Date coverage was or will be terminated;*

*(B) Reason for coverage termination; and*

*(C) List of dependents covered.*

*(102) Prostheses. An artificial extension that replaces a missing part of the body or supplements defective parts.*

*(103) Protected health information (PHI). Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.]*

*[(104)]***(57)** Provider. A physician, hospital, medical agency, specialist, or other duly*[-]*licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010*[(35)]***(19)**. Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

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

(C) Certified Nurse Midwife (CNM)—when acting within the scope of *[their]* **his/her** license in the state in which *[they]* **s/he** practice and performing a service which would be payable under this plan when performed by a physician;

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

**(E) Chiropractor;**

*[(E)]***(F)** Licensed Clinical Social Worker;

*[(F)]***(G)** Licensed Professional Counselor (LPC);

*[(G)]***(H)** Licensed Psychologist (LP);

*[(H)]***(I)** Nurse Practitioner (NP);

*[(I)]***(J)** Physician*[s]* Assistant (PA);

*[(J)]***(K)** *[Qualified]* Occupational Therapist;

*[(K)]***(L)** *[Qualified]* Physical Therapist;

*[(L)]***(M)** *[Qualified]* Speech Therapist;

*[(M)]***(N)** Registered Nurse Anesthetist (CRNA);

*[(N)]***(O)** Registered Nurse Practitioner (ARNP); or

*[(O)]***(P)** Therapist with a PhD or Master's Degree in Psychiatry or related field.

*[(105) Provider directory. A listing of network providers within a health plan.]*

*[(106)]***(58)** Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(107)]***(59)** 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.

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

*[(109) 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.*

*(110) Refractions. A record of the patient's preference for the focusing of the eyes that may then be used to purchase eyeglasses or contact lenses. It is the part of the exam that determines what prescription lens gives the patient the best possible vision.*

*(111) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) 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.]*

*[(112)]***(61)** Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020*[(6)(B)]***(2)(D)** and is currently receiving a monthly retirement benefit from a public entity.

*[(113) Skilled nursing care. Services that must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.*

*(114) Skilled nursing facility (SNF). A public or private facility licensed and operated according to the law that provides—*

*(A) Permanent and full-time facilities for ten (10) or more resident patients;*

*(B) A registered nurse or physician on full-time duty in charge of patient care;*

*(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;*

*(D) A daily medical record for each patient;*

*(E) Transfer arrangements with a hospital; and*

*(F) A utilization review plan.*

*The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.]*

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

*[(116)]***(63)** Specialty care physician/specialist. A physician who is

not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(117)]***(64)** Specialty medications. High cost drugs that *[are primarily self-injectible but sometimes oral medications]* **treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis**.

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

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

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

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

*[(122) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.*

*(123) Surgery center (ambulatory). A hospital-based, hospital-sponsored, or independently-owned facility that performs surgery.*

*(124) Survivor. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(A).]*

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

*[(126) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.*

*(127) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.]*

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

*[(A) Usual—The fee a provider 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 providers 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 providers for ninety percent (90%) of the procedures reported.*

*(129) 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.]*

*[(130)]***(71)** Vendor. The current applicable third-party administrator**s** of MCHCP benefits.

*[(131) Vested subscriber. A member who meets the requirements of subsection 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. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY RESCISSION

**22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions**. This rule established the policy of the board of trustees in regard to the subscriber agreement and general membership provisions of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify general membership provisions.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rescission is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency rescission complies*

*with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

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

## EMERGENCY RULE

### 22 CSR 10-3.020 General Membership Provisions

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

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

(2) Eligibility Requirements.

(A) Employee and Dependent Eligibility Requirements. Health plans contracted with MCHCP must be made available to all eligible employees, their dependents, and retirees of the public entity. An eligible employee is one who is actively employed and meets the minimum number of hours worked per year as established by his/her employer. If the public entity allows elected/appointed officials to participate in medical coverage, the definition of an employee includes elected/appointed officials where applicable. The entity will determine the eligibility requirements of waiting periods, required number of working hours, pay status, and contribution levels.

(B) An employee cannot be covered as an employee and as a dependent.

1. An eligible employee may enroll eligible dependents as long as the eligible employee is also enrolled. Eligible dependents include:

A. Spouse.

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

(II) If one spouse is a state employee with MCHCP benefits and the other is a public entity employee with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one employer's plan. The spouses cannot have coverage in both places; and

B. Children.

(I) Children may be covered through the end of the month in which they turn twenty-six (26), if they meet one of the following criteria:

(a) Natural child of subscriber or spouse;

(b) Legally adopted child of subscriber or spouse;

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

(d) Stepchild of subscriber or spouse;

(e) Foster child of subscriber or spouse;

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

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

(h) Newborn of a subscriber or a covered dependent;

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

(j) Child who is twenty-six (26) or older and is permanently disabled in accordance with subsection (5)(C) only if such child was an MCHCP member the day before the child turned twenty-six (26).

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

(III) A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both

subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time.

(C) Changes in Dependent Status. If a covered dependent loses his/her eligibility, the public entity and subscriber must notify MCHCP within thirty-one (31) days to terminate his/her coverage effective the end of the month eligibility ceases.

(D) Retiree and Dependent Eligibility Requirements. A retiree and his/her dependents will remain eligible as long as the entity remains with MCHCP.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must provide all of the following:

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

(I) Submit proof of prior coverage and proof of eligibility for dependents if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had other insurance coverage for six (6) months immediately prior to his/her retirement.

2. Employees may continue coverage on their eligible dependents into retirement.

3. A retiree may only add dependents to his/her coverage when—

A. A life event occurs; or

B. A dependent's employer-sponsored coverage ends due to one (1) of the following, provided that the dependent's employer-sponsored coverage was in place for twelve (12) months immediately prior to the loss, and MCHCP coverage is requested within sixty (60) days of the termination date of the previous coverage:

(I) Termination of employment;

(II) Retirement; or

(III) Termination of group coverage by the employer.

4. A retiree and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

(3) Enrollment Procedures.

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

(B) Open Enrollment.

1. An employee may elect coverage and/or change coverage levels during the annual open enrollment period if one (1) of the following occurred:

A. Waived his/her right to insurance when first eligible;

B. Did not enroll eligible dependents when first eligible; or

C. Dropped his/her or dependent coverage during the year.

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

(C) Special Enrollment Periods.

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

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. A retiree may apply for dependent coverage if one (1) of the following occurs:

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. MO HealthNet or Medicaid status loss. If an employee who is not retired, survivor, or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss.

4. Qualified Medical Child Support Order. If a subscriber receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent(s) in an MCHCP plan within sixty (60) days of the court order.

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

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

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her eligible dependent(s), or an employee rehired after his/her coverage terminates, and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date as determined by the employer.

2. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with, or after the eligibility date and applicable waiting period. The effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP except for newborns.

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

A. If enrollment by an employee is made before a wedding date, spouse's coverage becomes effective on the wedding date. The monthly premium is not prorated;

B. If enrollment by an employee is made within thirty-one (31) days of a wedding date, spouse's coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

C. If enrollment by a subscriber is made for a newborn of a member, the effective date for the newborn is the birth date. If enrollment is made by an employee due to the birth of a newborn of the employee, the effective date for the employee and newborn is the first of the month coinciding with or after enrollment is received;

D. If enrollment by an employee is made within thirty-one (31) days after the eligibility date, for an adoption, or placement of adopted children, coverage becomes effective on the eligibility date or the first day of the calendar month coinciding with or after the date the enrollment is received; or

E. If enrollment by an employee is made due to legal

guardianship of a dependent within thirty-one (31) days of guardianship effective date, the effective date for the dependent is the first day of the calendar month coinciding with or after the date the enrollment is received.

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

5. When a dependent of a subscriber first becomes eligible, coverage will become effective on the eligibility date or the first day of the month coinciding with or after the eligibility date if enrollment is made within thirty-one (31) days of the eligibility date.

6. A Qualified Medical Child Support Order is effective the first of the month coinciding with or after the form is received by the plan or date specified by the court.

(5) Proof of Eligibility.

(A) A public entity is required to obtain and keep on file proof of eligibility for dependents enrolled in an MCHCP medical, dental, and/or vision plan. Proof of eligibility documentation is required for all dependents.

1. Notification of the proof of eligibility policy will occur during the September 2012 public entity payroll representatives' informational meetings. Initial time frame for a public entity to obtain proof of eligibility documentation will occur September 1, 2012, through November 29, 2012.

2. Proof of eligibility must be obtained within thirty-one (31) days for a newly enrolled dependent and within ninety (90) days from date of birth for a newborn.

3. Coverage is provided for a newborn of a member from the moment of birth. The public entity or member must notify the plan of the birth verbally or in writing within thirty-one (31) days of the birth date. The plan will notify the public entity and member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later.

4. MCHCP reserves the right to request proof of eligibility be provided at any time. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will be terminated or will not take effect.

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

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

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

7. Annually, MCHCP will require a signed attestation form verifying receipt of proof of eligibility from the public entity with enrolled dependents. A blank attestation form will be delivered to the public entity prior to open enrollment. Instructions to complete the form, filing requirements, and deadlines will accompany the attestation form.

(B) The employee is required to notify MCHCP on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number.

(C) Permanently disabled children will continue to be eligible beyond age twenty-six (26) during the continuance of a permanent disability, provided the following documentation is submitted to the public entity prior to the dependent's twenty-sixth birthday:

1. The Supplemental Security Income (SSI) Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

2. A letter from the dependent's physician describing the disability and verifying that the disability pre-dates the SSA determination; and

3. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

(D) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided.

(6) Military Leave.

(A) Military Leave for an Employee who is not Retired.

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

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for COBRA coverage. The agency payroll representative notifies MCHCP of the effective date of military leave.

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

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

5. The former employee must submit a form within thirty-one (31) days of the employee's return to work for the same level of coverage with the same plan to be reinstated. The former employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work.

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

(B) Military Leave for a Retired Member.

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

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

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

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

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

(7) Termination.

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

1. Failure to make any required contribution toward the cost of coverage;

2. Entry into the armed forces of any country as defined in section (6);

3. With respect to employees, termination of coverage shall occur upon termination of employment, except as expressly specified otherwise in this rule. Termination of employee's coverage shall terminate the coverage of dependents;

4. With respect to dependents, termination of coverage shall occur upon divorce or legal separation from the subscriber or when a child reaches age twenty-six (26). A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. The public entity shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter;

5. Death of dependent-the dependent's coverage ends on the date of death.

A. The public entity shall notify MCHCP of a dependent's death;

6. Termination due to a member's act, practice, or omission that constitutes fraud or the member makes an intentional misrepresentation of material fact;

7. Termination due to a member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP;

8. A rescission will apply only to non-payment of a premium, fraud, or intentional misrepresentation. MCHCP shall provide at least thirty (30) days written notice before it rescinds coverage;

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

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

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP, unless the subscriber notifies MCHCP on the first calendar day of the month; then cancellation of coverage is effective the last day of the previous month.

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

(B) A subscriber may retroactively cancel coverage on his/her spouse to be effective on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request.

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

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

1. Upon retirement; or

2. When beginning a leave of absence.

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

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

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

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, eligible dependents can be added to the subscriber's plan upon notification to MCHCP. The subscriber may also add eligible dependents during open enrollment.

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

4. 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.

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

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

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

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

(B) Premium Payments.

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

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

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

(C) Required Notifications.

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

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

(D) Election Periods.

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

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

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

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

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

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

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

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

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

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

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

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

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

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

(B) If continuation coverage is not chosen within the proper time frames listed below, continuation of coverage ends—

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

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

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

A. A form for election to continue the coverage;

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

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

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

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

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

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

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

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

(11) Medicare.

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

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

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

(12) Communications to Members.

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

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

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

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

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

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the* ***Code of State Regulations****. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission and rule covering this same material is published in this issue of the* ***Missouri Register****.*

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

## EMERGENCY AMENDMENT

**22 CSR 10-3.045 Plan Utilization Review Policy**. The Missouri Consolidated Health Care Plan is amending section (1).

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

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

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

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

A. Ambulance services for non-emergen*[cy]***t** use whether air or ground;

**B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;**

*[B.]***C.** Applied behavior*[al]* analysis for autism;

**D. Auditory brainstem implant (ABI);**

**E. Bariatric procedures;**

*[C.]***F.** Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;

*[D.]***G.** Chiropractic services after twenty-six (26) visits annually;

*[E]***H.** Cochlear implant device;

**I. Chelation therapy;**

*[F.]***J.** Dental care to reduce trauma and restorative services when the result of accidental injury;

*[G.]***K.** Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

*[H.]***L.** Genetic testing or counseling;

*[I.]***M.** Home health care and palliative services;

*[J.]***N.** Hospice care;

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

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

*[M.]***Q.** Nutritional counseling after three (3) sessions annually;

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

*[O. Oxygen provided on an outpatient basis;]*

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

**T. Procedures with codes ending in "T";**

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

*[R.]***V.** Skilled nursing facility;

*[S.]***W.** Surgery (outpatient)—The following outpatient surgical procedures: **cornea transplant,** potential cosmetic surgery, sleep apnea surgery, implantable stimulators, **stimulators for bone growth,** surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams)*; [surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitus; incision of accessory sinuses, salivary glands, or ducts; or frenectomy);]* and

*[T.]***X.** Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications*[. Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider]*;

C. Medications that may be prescribed for several conditions**,** including some *[where]* **for which** treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of the inpatient admission to certify the necessity of the continued stay in the hospital. *[Participants]* **Members** who have another primary carrier, including Medicare, are not subject to this provision; and

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

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is amending sections (1)–(4); adding section (5); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 1000 Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars ($1,000); family *[limit]* each calendar year, three thousand dollars ($3,000). Non-network: per individual each calendar year, two thousand dollars ($2,000); family *[limit]* each calendar year, six thousand dollars ($6,000).

(C) During a hospital admission for delivery, only the **covered** mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

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

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

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

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

**(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.**

(3) Copayments—set charges for the following *[types of claims so]* **services apply as** long as network providers are utilized **unless otherwise specified**. **Copayments do not apply to the deductible or out-of-pocket maximum.**

(A) Office visit—Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.

**1. Vision office visit or refraction—thirty dollars ($30).**

**2. Hearing test—performed by a primary care physician: twenty dollars ($20); performed by a specialist: thirty dollars ($30).**

(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; **lab–covered at one hundred percent (100%); other diagnostic tests–ninety percent (90%) coinsurance after deductible;** Non-network: **all services paid at** seventy percent (70%) coinsurance after deductible.

*[(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.]*

*[(D)]***(C)** Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

*[(E)]***(D)** Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

**(E) Bariatric surgery—five hundred dollar ($500) copayment and ten percent (10%) coinsurance after deductible is met.**

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

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

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

*[(A)]***(C)** Network out-of-pocket maximum for individual—four thousand five hundred dollars ($4,500).

*[(B)]***(D)** Network out-of-pocket maximum for family—thirteen thousand five hundred dollars ($13,500).

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

*[(D)]***(F)** Non-network out-of-pocket maximum for family—thirty thousand dollars ($30,000).

*[(E)]***(G)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the *[U]***u**sual, *[C]***c**ustomary, and *[R]***r**easonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

*[(5)]***(6)** 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. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is amending sections (1)–(4); adding section (5); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 2000 Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars ($2,000); family *[limit]* each calendar year, six thousand dollars ($6,000). Non-network: per individual each calendar year, four thousand dollars ($4,000); family *[limit]* each calendar year, twelve thousand dollars ($12,000).

(C) During a hospital admission for delivery, only the **covered** mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan member, the newborn's claims**

**will be subject to deductible and coinsurance during the hospital admission.**

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

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

**(E) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.**

(3) Copayments—set charges for the following *[types of claims so]* **services apply as** long as network providers are utilized. **Copayments do not apply to the deductible or out-of-pocket maximum.**

(A) Office visit—Network: primary care—twenty-five dollars ($25), specialist—thirty-five dollars ($35); Non-network: sixty percent (60%) coinsurance after deductible.

**1. Vision office visit or refraction—thirty-five dollars ($35).**

**2. Hearing test primary care—twenty-five dollars ($25); specialist: thirty-five dollars ($35).**

(B) Maternity—Network: primary care—twenty-five dollars ($25) for initial visit, specialist—thirty-five dollars ($35) for initial visit; **lab—covered at one hundred percent (100%); other diagnostic tests—eighty percent (80%) coinsurance after deductible;** Non-network: **all services paid at** sixty percent (60%) coinsurance after deductible.

*[(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.]*

*[(D)]***(C)** Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

*[(E)]***(D)** Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

**(E) Bariatric surgery—five hundred dollar ($500) copayment and twenty percent (20%) coinsurance after deductible is met.**

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

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

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

*[(A)]***(C)** Network out-of-pocket maximum for individual—six thousand dollars ($6,000).

*[(B)]***(D)** Network out-of-pocket maximum for family—eighteen thousand dollars ($18,000).

*[(C)]***(E)** Non-network out-of-pocket maximum for individual—twelve thousand dollars ($12,000).

*[(D)]***(F)** Non-network out-of-pocket maximum for family—thirty-six thousand dollars ($36,000).

*[(E)]***(G)** Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the *[U]***u**sual, *[C]***c**ustomary, and *[R]***r**easonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

*[(5)]***(6)** 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. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

## EMERGENCY RESCISSION

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges**. This rule established the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rescission is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency rescission complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure*

*fairness to all interested persons and parties under the circumstances. This emergency rescission was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

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

## EMERGENCY RULE

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

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

*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.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Benefit Provisions Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and High Deductible Health Plan (HDHP). Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Covered Charges Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.

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

1. Prescribed by an appropriate health care provider for the therapeutic treatment of injury or sickness;

2. To the extent they do not exceed any limitation or exclusion; and

3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided, 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, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and

2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A physician visit to seek a second opinion is a covered service.

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

(E) Medical plan benefits, limitations, and exclusions effective January 1, 2012, are incorporated by reference into this rule and are available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, or online at www.mchcp.org. This rule does not include any later amendments or additions.

(F) Plan benefits for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically significant allergic symptoms. 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;

2. Ambulance service. Ambulance transport services involve the use of specially designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty thousand dollar ($40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically-necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

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

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

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

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

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

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

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

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

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

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

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

20. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every

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

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

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

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

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

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

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

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

24. Hospital (includes inpatient, outpatient and surgical centers). The following benefits are covered:

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

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(III) A state-licensed psychologist;

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

(V) Licensed professional counselor;

25. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two (2)-visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating

habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider.

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets-covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle–foot/knee–ankle–foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

32. Preventive services.

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

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

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

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

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One exam (1) per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings:

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

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

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

(IV) Colorectal Screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive regardless of diagnosis. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza). The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out-of-network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically necessary preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related;

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

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

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

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

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ($VO_2$max) equal to or less than twenty milliliter per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

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

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation: direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion

failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

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

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

(III) Meals—not covered.

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

(I) Allogenic bone marrow—one hundred forty three thousand dollars ($143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars ($121,000);

(III) Heart—one hundred twenty-eight thousand dollars ($128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars ($133,000);

(V) Lung—one hundred fifty-one thousand dollars ($151,000);

(VI) Kidney—Fifty-four thousand dollars ($54,000);

(VII) Kidney and Pancreas—ninety-seven thousand dollars ($97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars ($153,000);

38. Urgent care. Services to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission and rule covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-3.075 Review and Appeals Procedure**. The Missouri Consolidated Health Care Plan is amending sections (1)–(5); adding section (1); and renumbering as necessary.

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

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

*[(1)]***(2)** Claims Submissions and Initial Benefit Determinations.

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

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

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

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

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be

submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

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

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

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

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

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

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based**,** with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

*[(2)]***(3)** General Appeal Provisions.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave *[rights]* **rise** to the appeal.

*[(3)]***(4)** Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage *[once]* **after** an individual has been covered under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical *[and pharmacy]* benefits administered by *[plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc.,]* **Coventry Health Care** in accordance with state law and regulations promulgated by DIFP *[and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010]*. **The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR and Express Scripts Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).**

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the *[DIFP]* external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective

retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review *[by DIFP]* **except as specifically provided in 22 CSR 10-3.075(4)(A)4**.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 8086
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through *[Mercy Health Plans]* **Coventry Health Care**—

(a) First and second level appeals must be submitted in writing to—

*[Mercy Health Plans*
*Attn: Corporate Appeals*
*14528 S. Outer 40 Road, Suite 300*
*Chesterfield, MO 63017]*
**Coventry Health Care**
**Attn: Appeals Department**
**550 Maryville Centre, Ste. 300**
**St. Louis, MO 63141**

(b) Expedited appeals must be communicated by calling *[Mercy Health Plans]* **Coventry Health Care** telephone *[1-800-830-1918, ext. 2394]* **1-314-214-2394** or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
*[Clinical Appeals—MH3*
*6625 West 78th Street, BL0390]*
**Attn: Pharmacy Appeals—MH3**
**Mail Route 0390**
**6625 W. 78th St.**
Bloomington, MN 55439
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30)

days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

**(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.**

**(II) The claimant can submit an external review request in writing to—**

**Office of Consumer Information and Oversight**
**Department of Health and Human Services**
**PO Box 791**
**Washington DC 20044**
**or by fax to 1-202-606-0036**
**or by email to disputedclaim@opm.gov**

**(III) The claimant may call the toll-free number 1-877-549-8152 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.**

**(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.**

**(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.**

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

*[(4)]***(5)** Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

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

*[(5)]***(6)** In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.

(A) 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) Agency error—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, *[the]* MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. **Plan changes are effective February 1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Wellness Program]* **Lifestyle Ladder** participation—MCHCP may deny all appeals regarding continuation of participation in the *[Wellness]* **Lifestyle Ladder** Program due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY AMENDMENT

**22 CSR 10-3.090 Pharmacy Benefit Summary**. The Missouri Consolidated Health Care Plan is deleting sections (2), (4), and (8);

amending the purpose, sections (1), (5), and (7); adding sections (6)–(8); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP with HSA of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, [and] PPO 2000 Plan,* ***and HDHP with HSA*** *of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency amendment complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) The pharmacy benefit provides coverage for prescription drugs**.** *[listed on the formulary, as described in the following:]* **Vitamins and nutrients coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.**

(A) *[Medications]* **PPO 600, PPO 1000, and PPO 2000 Prescription Drug Coverage**.

1. Retail—Network:

A. Generic: Eight-dollar ($8) copayment for up to a thirty (30)-day supply for **a** generic drug on the formulary**; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**;

B. Brand: Thirty-five-dollar ($35) copayment for up to a thirty (30)-day supply for **a** brand drug on the formulary**; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)**;

**C. Non-formulary: One hundred dollar ($100) copayment for up to a thirty (30)-day supply for a drug not on the formulary;**

*[C.]***D.** *[Mail order]* **Home delivery** program—

(I) *[Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for a twenty-dollar ($20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent ($87.50) copayment for a brand drug on the formulary.]* **Maintenance prescriptions may be filled through the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits.**

**(a) Generic: Twenty dollar ($20) copayment for up to a ninety (90)-day supply for a generic drug on the formulary.**

**(b) Brand: Eighty-seven dollars and fifty cents ($87.50) copayment for up to a ninety (90)-day supply for a brand drug on the formulary.**

**(c) Non-formulary: Two hundred fifty dollar ($250) copayment for up to a ninety (90)-day supply for a drug not on the formulary; and**

(II) Specialty drugs covered only through network *[mail order]* **home delivery** for up to thirty (30) days. *[Copayments—]* **The first specialty prescription order may be filled through a retail pharmacy.**

(a) Generic: *[e]***Eight dollars ($8) for generic drug on the formulary list***[; and]***.**

(b) Brand: *[t]***Thirty-five dollars ($35) for brand drug on the formulary.**

**(c) Non-formulary: One hundred dollar ($100) copayment for a drug not on the formulary;**

**E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;**

**F. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment;**

**G. If the physician allows for generic substitution and the member chooses a brand name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and**

**H. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.**

2. *[Non-network pharmacies]* **Retail—Non-network:***[—]* If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. *[S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment or coinsurance. All such claims must be filed within twelve (12) months of the incurred expense.]* **The pharmacy vendor will reimburse the cost of the drug based on the network discounted amount, less the applicable copayment.**

**A. Generic: Eight dollar ($8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary.**

**B. Brand: Thirty-five dollar ($35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary.**

**C. Non-formulary: One hundred dollar ($100) copayment for up to a thirty (30)-day supply for a drug not on the formulary.**

*[3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.]*

**(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.**

**1. Retail—Network:**

**A. Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; tobacco cessation prescriptions covered at 100%;**

**B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; tobacco cessation prescriptions covered at 100%;**

**C. Non-formulary: Thirty percent (30%) coinsurance**

**after deductible for a drug not on the formulary;**

**D. Home delivery program.**

**(I) Maintenance prescriptions may be filled through the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits.**

**(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.**

**(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.**

**(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary.**

**(II) Specialty drugs covered only through network home delivery for up to thirty (30) days.**

**(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.**

**(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.**

**(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary; and**

**E. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.**

**2. Retail—Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. The pharmacy vendor will reimburse the cost of the drug based on the network discounted amount, less the applicable coinsurance.**

**A. Generic: Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a generic drug on the formulary.**

**B. Brand: Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a brand drug on the formulary.**

**C. Non-formulary: Fifty percent (50%) coinsurance after deductible for up to a thirty (30)-day supply for a drug not on the formulary.**

*[(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.]*

*[(3)]***(2)** Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;

2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.

*[(4) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.]*

*[(5)]***(3)** Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; *[and]*

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include:

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply*[.]***; and**

**(C) Members must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted price as determined by the vendor minus any applicable copayment. Members are responsible for any charge over the network discounted price and the applicable copayment.**

*[(6)]***(4)** Formulary—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or

(C) A drug is determined to have a safety issue.

*[(7)]***(5)** *[Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug.]* **Grandfathered Specialty Drugs—Prescription drugs grandfathered for members in 2011 because they had taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011, will continue to be covered at a thirty-five dollar ($35) brand copayment level if enrolled in a PPO plan or at twenty percent (20%) coinsurance if enrolled in the HDHP plan.** Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

**(D) Attention-deficit hyperactivity disorder (ADHD);**

*[(D)]***(E)** Biologics for inflammatory conditions;

*[(E)]***(F)** Cancer drugs;

*[(F)]***(G)** Hemophilia drugs (*[F]***f**actor VIII and IX concentrates);

*[(G)]***(H)** Hepatitis drugs;

*[(H)]***(I)** Immunosuppressants (transplant anti-rejection agents);

*[(I)]***(J)** Insulin (basal);
*[(J)]***(K)** Low molecular weight heparins;
*[(K)]***(L)** Multiple sclerosis injectable drugs;
*[(L)]***(M)** Novel psychotropics (oral products and long-active injectables);
*[(M)]***(N)** Phosphate binders;
*[(N)]***(O)** Pulmonary hypertention drugs; and
*[(O)]***(P)** Somatostatin analogs.

*[(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.]*

**(6) Medicare Part B Prescription Drugs—For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:**
**(A) Diabetes testing and maintenance supplies;**
**(B) Respiratory agents;**
**(C) Immunosuppressants; and**
**(D) Oral anti-cancer medications.**

**(7) Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the Food and Drug Administration and medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.**

**(8) Guidelines for Drug Use—If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

### EMERGENCY RULE

### 22 CSR 10-3.100 Fully-Insured Medical Plan Provisions

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

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

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

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*