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**Rules of**  
**Missouri Consolidated**  
**Health Care Plan**  
**Division 10—Health Care Plan**  
**Chapter 2—Plan Options**

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

**22 CSR 10-2.010 Definitions**

*PURPOSE: This rule establishes the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.*

(1) When used in this plan document, these words and phrases have the meaning—

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

(B) Actively at work—You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday;

(C) Administrative guidelines—The interpretation of the plan document as approved by the plan administrator, developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered;

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

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

(F) Benefits—Amounts payable by the plan as determined by the summary of benefits (22 CSR 10-2.040), covered charges (22 CSR 10-2.050(2)) and limitations (22 CSR 10-2.060) as interpreted by the plan administrator;

(G) Claims administrator—An organization or group responsible for the processing of claims and associated services for the indemnity plans;

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

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

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

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

(L) Dependents—The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in this plan document, for whom application has been made and has been accepted for participation in the plan;

(M) Eligibility date—Refer to 22 CSR 10-2.020 for effective date provisions.

1. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.

2. Employees transferred from a department or other public entity with coverage under another medical care plan into a department or other public entity covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation immediately.

3. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the indemnity plan, will be eligible for participation immediately.

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

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

1. Employed on a full-time basis;

2. Eligible for group health benefits in his/her own behalf;

3. Maintaining a residence separate from his/her parents or guardian— except for

full-time students in an accredited school or institution of higher learning;

4. Married; or

5. Not dependent upon parents or guardian for at least fifty percent (50%) support;

(O) Employee and dependent participation—Participation of an employee and the employee's eligible dependents. Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren). Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 20 CSR 10-2.020(1)—(9);

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

(Q) Employees—Employees of the state and other public entities and present and future retirees from state and other public entity employment who meet the eligibility requirements as prescribed by state law or other public entity who have applied and have been accepted for membership in the plan;

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

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

(T) Home health agency—An agency certified by the Missouri Department of Health, or any other state's licensing or certifying body, to provide health care services to persons in their homes;

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

(V) Hospital.

1. An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

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

3. An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital

under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of P.L. 89-97).

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

5. A residential alcoholism, chemical dependency or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction. In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility (SNF), nursing home, rest home or facility for the aged;

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

(X) Medical benefits coverage—Services that are received from providers recognized by the plan, including services provided by chiropractic physician, and are covered benefits under the plan.

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

(Z) Medicare HMO (risk contract)—An HMO exclusively for members residing in specified areas and covered by Medicare whereby benefits are provided in accordance with a plan approved by federal regulations;

(AA) 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 meet the requirements of a hospital as defined in this rule;

(BB) Open enrollment period—A period designated by the plan during which members 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;

(CC) Participant—Any employee or dependent who has been accepted for membership in the plan;

(DD) Physically or mentally disabled—The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition;

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

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

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

(HH) Plan document—This statement of the terms and conditions of the plan revised and effective January 1, 1995, as adopted by the plan administrator;

(II) Plan year—Same as benefit year;

(JJ) Point of service—A plan which provides a wide range of comprehensive health care services, like an HMO if in-network providers are utilized and like an indemnity plan if non-network providers are utilized;

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

(LL) Preferred Provider Organization (PPO)—An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers;

(MM) Prior plan—The terms and conditions of a plan in effect for a period preceding January 1, 1995;

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

(OO) 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;

(PP) Review agency—A company responsible for administration of the four (4) components of the Health Check program under the direction of the claims administrator;

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

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

1. It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24)-hour-a-day nursing service by one (1) or more professional nurses and nursing person-

nel as are needed to provide adequate medical care;

2. It provides the services under the supervision of a proprietor or employee who is a physician or RN; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or RN; and

3. An SNF shall be deemed to include institutions meeting the criteria in subsection (1)(RR) which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of P.L. 89-97);

(SS) State—Missouri;

(TT) Unemancipated child(ren)—A natural child(ren) and a legally adopted child(ren), a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan) and, if domiciled with the employee in a normal parent-child relationship, the following:

1. Stepchild(ren);

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

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

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. This child(ren) must rely on the parent/custodian for his/her major financial support (appropriate documentation may be required). Except for a disabled child(ren) as described in subsection (1)(TT), an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-three (23) (twenty-five (25) if attending school full-time and the public entity joining the plan had immediate previous coverage allowing this provision) (see 22 CSR 10-2.020(5)(D)2. for continuing coverage on handicapped child(ren) beyond age twenty-three (23)); and

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

(UU) Usual, customary, and reasonable charge.

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

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

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

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

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

\*Original authority 1992.

## 22 CSR 10-2.020 Membership Agreement and Participation Period

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

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

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

1. For groups of less than five hundred (500) employees, the MCHCP will be the only health care offering made to its eligible members. For groups of five hundred (500) or more employees the entity may maintain a self-insured indemnity plan or one point-of-service (POS) option (either self-insured or on a full-insured directly contracted basis), but may not offer a competing plan of the same type through the MCHCP;

2. It will contribute at least twenty-five dollars (\$25) per month toward each active employee's premium;

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

4. Eligible members joining the MCHCP who were covered by any medical plan offered by the public entity or an individual policy will not be subject to any pre-existing condition;

5. Eligible members joining the MCHCP at the time of the initial eligibility of the public entity will not have to prove insurability;

6. For groups contracting only with the MCHCP, at least seventy-five percent (75%) of all eligible employees must join the MCHCP. For groups of five hundred (500) employees or more that choose one of the alternative options identified in paragraph (1)(A)1., the entity must maintain seventy-five percent (75%) coverage of all their employees covered through all of their offerings;

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

8. Public entities joining the plan will be able to select whatever plans they wish from those available through the MCHCP to be offered to their eligible members;

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

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

(2) The employee membership agreement shall consist of the written application of the employee, the plan document as adopted by the board and duly executed amendments. The plan booklets and any associated administrative guidelines interpret the membership agreement for the benefit of members and administrators but are not a part of the membership agreement.

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

date of this plan, except that any participant confined to a hospital on the effective date of this plan shall be continued under the prior plan until discharged from the hospital.

(4) The effective date of participation shall be determined, subject to the effective date provision in subsection (4)(C), as follows:

(A) Employee Participation.

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

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date of application, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

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

(B) Dependent Coverage. Dependent participation cannot precede the employee's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once an employee is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided—

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

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

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

3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is not eligible for coverage until the next open enrollment period; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period;

(C) Effective Date *Proviso*.

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

2. If any dependent, other than a newborn child, is confined in a hospital on the date participation with respect to dependent coverage would otherwise become effective, participation shall become effective on the day after the date of discharge from the hospital; and

(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for

providing medical coverage for the dependent child(ren). (Note: This section does not include dependents of retirees or long-term disability recipients covered under the plan.)

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

(A) Written request by the employee;

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

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

(D) Determination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (6) and (7).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally retarded and/or physically handicapped children will continue to be eligible beyond age twenty-three (23) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-third birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (7).

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

(7) Continuation of Coverage.

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

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

2. The active employee was eligible for a retirement benefit at the time of death provided coverage had been in effect for two (2) years, or since first eligible.

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

1. Covered under the plan for a period of at least two (2) years prior to termination of employment or since first eligible; and

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents who have been covered under the plan for two (2) years immediately prior to termination of employment or continuously from the date of first eligibility if less than two (2) years. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, long-term disability recipients and their dependents are not later eligible if they discontinue their coverage at some future time.

(C) Coverage at Termination—A former employee may continue participation in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity or the Highway Retirement System when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to continue coverage must be made within sixty (60) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence—An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member

of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment directly from the leave without proof of insurability, but they will be subject to preexisting limitations. Preexisting limitations under this provision will not apply to HMO members. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (5)(C). Coverage may be reinstated upon return from military leave without proof of insurability or preexisting conditions. However, the former member must complete an enrollment form.

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

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

(G) Reinstatement After Dismissal—If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the

employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. No preexisting condition limitation will apply. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. If the employee participates in an indemnity plan, the pre-existing condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.

(8) Federal Consolidated Omnibus Budget-Reconciliation Act (COBRA).

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

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

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

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

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

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

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

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

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

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

(A) You continue to maintain coverage under the thirty-six (36)-month provision of COBRA; and

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

*AUTHORITY: section 103.059, RSMo 1994.\* Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed March 17, 1997, effective July 1, 1997, expired Sept. 22, 1997. Amended: Filed March 17, 1997, effective Aug. 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 18, 1998, effective Jan. 1, 1999, expired June 29, 1999. Amended: Filed Dec. 18, 1998, effective June 30, 1999.*

*\*Original authority 1992.*



MISSOURI CONSOLIDATED HEALTH CARE PLAN  
P.O. BOX 104355  
JEFFERSON CITY, MO 65110

**ENROLLMENT/CHANGE/CANCELLATION FOR** \_\_\_\_\_  
NAME OF PLAN

**ACTION:**  NEW ENROLLMENT  CHANGE  CANCEL INSURANCE

**SECTION A**

1. SOCIAL SECURITY NUMBER \_\_\_\_\_ 2. NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_

3. ADDRESS (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP CODE) \_\_\_\_\_ COUNTY CODE \_\_\_\_\_

4. WORK PHONE ( ) \_\_\_\_\_ 5. HOME PHONE ( ) \_\_\_\_\_

6. DATE OF BIRTH (MM/DD/YY) \_\_\_\_\_ 7. DATE OF EMPLOYMENT (MM/DD/YY) \_\_\_\_\_

8. MARITAL STATUS  MARRIED  SINGLE  WIDOWED 9. SEX  FEMALE  MALE

**SECTION B**

10. I would like the following coverage: (Check one)  
 MEMBER ONLY (MI)  MEMBER/SPOUSE (MS)  
 MEMBER/CHILDREN (MC)  MEMBER/SPOUSE & CHILDREN (MF)

11. Are you or any of your dependents covered by another insurance policy?  YES  NO

12. If newly married, date of marriage ►

13. Member and dependents to be enrolled, deleted, changed: (Attach sheet if necessary)

ENROLL/DELETE/CHANGE	MEMBER/DEPENDENT SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	MI.	DATE OF BIRTH	RELATIONSHIP	SEX M OR F	PHYSICIAN OR MEDICAL CENTER (FOR HMO OR POS)

**SECTION C**

If your spouse is currently employed by the state of Missouri or in a position in which they are eligible for insurance coverage through MCHCP, please complete the following information:

EMPLOYER AND DEPARTMENT NAME \_\_\_\_\_

SPOUSE'S SOCIAL SECURITY NUMBER \_\_\_\_\_ SPOUSE'S FULL NAME (LAST, FIRST, MIDDLE) \_\_\_\_\_

**SECTION D**

I hereby make the above designation(s) and authorize, if applicable, the deduction necessary to pay for the coverage elected. I also hereby authorize the appropriate providers to release any documentation necessary to pay my or my dependent's claims. The effective date for this coverage should be  / 01 /   
MM DD YY

SIGNATURE OF MEMBER \_\_\_\_\_ DATE \_\_\_\_\_

**SECTION E**

EFFECTIVE DATE (MONTH/DAY/YEAR) \_\_\_\_\_ AMOUNT OF DEDUCTION \_\_\_\_\_ CODE \_\_\_\_\_

PERSONNEL PAYROLL USE SIGNATURE OF PAYROLL/PERSONNEL CLERK \_\_\_\_\_ DATE \_\_\_\_\_ DEPT./DIV./SECT. NO. \_\_\_\_\_



MISSOURI CONSOLIDATED HEALTH CARE PLAN  
LEAVE OF ABSENCE - DIRECT BILL/BACK TO WORK

(PLEASE PRINT OR TYPE)

<b>SECTION A</b>	1. SOCIAL SECURITY NUMBER		2. NAME (LAST)			2. NAME (FIRST)		2. NAME (MI)										
	3. ADDRESS (STREET)			3. ADDRESS (CITY)		3. ADDRESS (STATE)		3. ADDRESS (ZIP) (COUNTY)										
<b>SECTION B</b>	DEPT. NUMBER	DIVISION NUMBER		SECTION NUMBER														
	Retirement system type: (Check one) <input type="checkbox"/> Regular State (REG) <input type="checkbox"/> Elected Official (REG) <input type="checkbox"/> Legislative Clerk (REG) <input type="checkbox"/> Legislator (LEG) <input type="checkbox"/> Admin. Law Judge (ALJ) <input type="checkbox"/> Judge (JDG) <input type="checkbox"/> Public School Retirement (TCH)																	
<b>TO BE COMPLETED BY EMPLOYER</b>	<b>EMPLOYER COMPLETES WHEN AN EMPLOYEE IS GOING ON A LEAVE STATUS.</b>																	
	Leave of absence due to: (Check one of the following) <input type="checkbox"/> Illness of employee <input type="checkbox"/> Maternity <input type="checkbox"/> Layoff <input type="checkbox"/> Workers' Compensation Case No. _____ <input type="checkbox"/> Other, please specify ▶ _____ Effective date of leave ▶ <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; text-align:center;">MONTH</td><td style="width:20px; text-align:center;">DAY</td><td style="width:20px; text-align:center;">YEAR</td></tr><tr><td> </td><td> </td><td> </td></tr></table> Last deduction for medical care will be made on the ▶ <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; text-align:center;">MONTH</td></tr><tr><td> </td></tr></table> payroll for ▶ <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; text-align:center;">MONTH</td></tr><tr><td> </td></tr></table> coverage.									MONTH	DAY	YEAR				MONTH		MONTH
MONTH	DAY	YEAR																
MONTH																		
MONTH																		
<b>TO BE COMPLETED BY THE EMPLOYEE</b>	<b>EMPLOYER COMPLETES WHEN AN EMPLOYEE IS RETURNING TO WORK.</b>																	
	Effective date of return ▶ <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; text-align:center;">MONTH</td><td style="width:20px; text-align:center;">DAY</td><td style="width:20px; text-align:center;">YEAR</td></tr><tr><td> </td><td> </td><td> </td></tr></table> Medical care coverage deduction will start on the ▶ <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; text-align:center;">MONTH</td></tr><tr><td> </td></tr></table> for <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; text-align:center;">MONTH</td></tr><tr><td> </td></tr></table> coverage.									MONTH	DAY	YEAR				MONTH		MONTH
MONTH	DAY	YEAR																
MONTH																		
MONTH																		
<b>SECTION C</b>	<b>EMPLOYEE COMPLETES WHEN THE EMPLOYEE IS GOING ON A LEAVE STATUS.</b>																	
	During the period of time I am on leave of absence status, I wish to continue my medical coverage and be billed monthly for the required premium. 1. Medical Care Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No																	
<b>TO BE COMPLETED BY THE EMPLOYER</b>	SIGNATURE OF EMPLOYEE							DATE										
	SIGNATURE OF PAYROLL/PERSONNEL CLERK							DATE										
<b>SECTION D</b>	<b>DO NOT WRITE BELOW THIS LINE</b>																	
	STS DBL ▶			MED ▶			BEG. DATE		END DATE									
<b>SECTION E</b>																		
										<b>(MCHCP USE ONLY)</b>								

MO 048-0078 (12-93)

DISTRIBUTION: WHITE-MCHCP CANARY-EMPLOYER PINK-EMPLOYEE



**22 CSR 10-2.030 Contributions**

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

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

(2) The contribution by the employee shall be determined by the plan administrator for state employees and, within the underwriting guidelines set by the plan administrator, by the appropriate administrative unit for the public entities.

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

*AUTHORITY: section 103.059, RSMo 1994.\* Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995.*

*\*Original authority 1992.*

**22 CSR 10-2.040 Indemnity Plan Summary of Medical Benefits**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to medical benefits for participants in the Missouri Consolidated Health Care Plan Indemnity Plan.*

(1) Lifetime maximum, one (1) million dollars.

(2) Automatic Annual Reinstatement—Maximum, five thousand dollars (\$5,000).

(3) Deductible Amount—Per individual for the indemnity plan and the limited indemnity plan each calendar year, three hundred dollars (\$300), family limit each calendar year, nine hundred dollars (\$900).

(4) Copayment.

(A) Individual—Eighty percent (80%) of the first seven thousand five hundred dollars (\$7,500) of covered charges in the calendar year which are subject to coinsurance, one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and preferred provider organizations (PPO).

(B) Family—Eighty percent (80%) of the first fifteen thousand dollars (\$15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPO.

(C) Limited Indemnity Plan—Same as subsections (4)(A) and (B), except covered charges are reimbursed on a seventy percent (70%) basis.

(5) When a provider enrolled in a preferred provider network that has contracted with the plan administrator is used, the plan will pay ninety percent (90%) of the discounted rate for all covered charges after the deductible has been met. The deductible will be waived and the employee or dependent will only be responsible for a ten dollar (\$10) copayment for an office visit for covered services if a physician or provider is utilized who is enrolled in a preferred provider network that has contracted with the plan administrator. Charges for other covered services provided in addition to the office visit will be covered under the regular PPO benefit(s) available at the time of service.

(6) Hospital Room Charges—The hospital's most common charge for semiprivate accommodations, unless a private room has been recommended by a physician and approved by the claims administrator or the plan's medical review agency.

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

(A) Precertification—The medical necessity of a nonemergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate review agency. For emergency hospital admissions, the review agency must be notified within forty-eight (48) hours of

the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

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

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

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

(E) Penalties—Members not complying with subsections (10)(A) and (B) may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

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

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

(9) Prescription Drug Program—The indemnity plan provides a carve-out program for prescription drugs. The program consists of coverage for maintenance and nonmaintenance medications, as described in the following:

(A) Nonmaintenance Medications—For those prescription drugs needed for short-term use only, the member will be responsible for twenty percent (20%) of a discounted rate after satisfaction of the twenty-five dollar (\$25) individual deductible (seventy-five dollars (\$75) maximum family deductible).

1. The prescription must be written for less than a thirty (30)-day supply.

2. If the member chooses a brand name medication when there is a generic available, s/he will be responsible for twenty percent (20%) of the generic medication's cost (after satisfaction of the deductible), as well as the difference between the cost of the brand name medication and the generic medication. This difference does not apply to the out-of-pocket maximum. This provision does not apply if the doctor has indicated on the prescription that the brand name is necessary.

(B) Maintenance Medications—For those medications listed on the maintenance medication list, as determined by the claims administrator, the member will be responsible for a fifteen-dollar (\$15) copayment for each brand name medication and a five-dollar (\$5) copayment for each generic medication.

1. The prescription must be written for a thirty to ninety (30–90)-day supply.

2. Maintenance medications may be purchased from either a participating local pharmacy or the mail order facility.

3. Unless an exception is approved by the drug/claims administrator for a medically necessary reason, oral contraceptives must be obtained from an approved formulary list.

(C) Out-of-Pocket Maximum—There is a maximum out-of-pocket (including deductibles) of four hundred dollars (\$400) per individual, with a maximum family out-of-pocket of twelve hundred dollars (\$1200). The out-of-pocket maximum applies to both maintenance and nonmaintenance medications. Once a member has reached the four hundred dollar (\$400)-maximum his/her covered drugs will be covered at one hundred percent (100%) for the remainder of the calendar year.

(D) Nonparticipating Pharmacies—If a member chooses to use a nonparticipating pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at a participating pharmacy, less any applicable deductibles or coin-

urance. Any difference between the amount paid by the member at a nonparticipating pharmacy and the amount that would have been allowed at a participating pharmacy will not be applied to the out-of-pocket maximum.

*AUTHORITY: section 103.059, RSMo 1994. \* Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and re-adapted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998.*

*\*Original authority 1992.*

## 22 CSR 10-2.050 Indemnity Plan Benefit Provisions and Covered Charges

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

### (1) Benefit Provisions.

(A) Subject to the provisions and limitations of this plan document and the written application of the employee, the benefits, as provided in the summary of benefits, are payable for covered charges incurred by a participant while covered for this benefit, provided the deductible requirement, if any, is met.

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

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

(D) The total amount of benefits payable for all covered charges incurred during an

individual's lifetime shall not exceed the lifetime maximum specified in the summary of benefits, subject to reinstatement as provided in subsections (1)(E) and (F).

(E) An annual reinstatement of benefits previously paid will be made on each January 1 for each insured person, not to exceed the automatic annual reinstatement maximum on the summary of benefits. In no event will the reinstatement increase the lifetime maximum to an amount in excess of the lifetime maximum shown in the summary of benefits.

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

### (2) Covered Charges.

(A) Only charges for those services listed in this rule 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, and which are—*a)* prescribed by a doctor or provider for the therapeutic treatment of injury or sickness; *b)* to the extent they do not exceed any limitation; *c)* not excluded by the limitations; and *d)* for not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following: *a)* the medical benefits or supplies usually rendered or prescribed for the condition; and *b)* the usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

(C) Covered charges are divided into mutually exclusive types and each covered charge shall be deemed to be covered on the date the medical benefits, service or supply is received.

1. Type A charges for hospital daily room and board and routine nursing. The maximum covered charge for a private room is the hospital's most common semiprivate room rate unless a private room is recommended by a physician and approved by the claims administrator or the plan's medical review agency.

2. Type B charges for intensive care, concentrated care, coronary care or other special hospital unit designed to provide special care for critically ill or injured patients.

3. Type C charges for preadmission testing (X-ray and laboratory tests) which are

conducted and which are necessary for hospital admission and which are not duplicated for screening purposes upon admission to the hospital.

4. Type D special hospital charges for inpatient medical care and supplies received during any period room and board charges are made except—

A. Those included in paragraphs (2)(C)1.—3.; and

B. Special nursing care.

5. Type E charges for outpatient medical care or supplies.

6. Type F surgery and anesthesia charges of a provider for the giving of anesthesia not included in paragraphs (2)(C)4. and 5.

7. Type G psychiatric service charges of a provider licensed to provide services which relate to care of mental conditions.

8. Type H professional service charges not included in paragraphs (2)(C)2.—7. made by a provider or by a laboratory for diagnostic laboratory and X-ray exams.

9. Type I nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) on his/her own behalf.

10. Type J professional service charges of a licensed physical therapist, occupational therapist, audiologist or respiratory therapist, subject to medical necessity review by claims administrator.

11. Type K transportation charges not included in paragraphs (2)(C)3. and 4. for professional air or ground ambulance services for local transportation to and from a hospital, from a hospital to and from a local facility which provides specialized testing or treatment or from a hospital to a skilled nursing facility; and charges for travel within the United States by a scheduled railroad, airline or ambulatory carrier to, but not back from, the nearest hospital equipped to furnish needed special treatment.

12. Type L charges for orthopedic or prosthetic devices and hospital-type equipment not included in paragraphs (2)(C)4. and 5. for—

A. Man-made limbs or eyes for the replacing of natural limbs or eyes;

B. Casts, splints or crutches;

C. Purchase of a truss or brace as a direct result of—

(I) An injury or sickness which began while covered under these rules; or

(II) A disabling condition existing since birth;

D. Oxygen and rental of equipment for giving oxygen; rental of wheelchair or hospital equipment to aid in breathing;

E. Dialysis equipment rental, supplies, upkeep and the training of the participant or an attendant to run the equipment; and

F. Colostomy bags and ureterostomy bags.

13. Type M charges for prescription drugs from a licensed pharmacist or for anesthesia when given by a provider if not included in paragraphs (2)(C)3.—6.

14. Type N charges for skilled nursing care including room and board when the stay is medically necessary, as determined by the claims administrator.

15. Type O charges for the services of a licensed speech therapist if the charges are made for speech therapy used for the purpose of correcting speech loss or damage which—

A. Is due to a sickness or injury, other than a functional nervous disorder or surgery due to such sickness or injury; or

B. Follows surgery to correct a birth defect.

16. Type P charges for services and supplies from a home health care agency which are medically necessary, as determined by the claims administrator.

17. Type Q charges for outpatient treatment of mental and nervous conditions.

18. Type R charges for outpatient treatment of alcohol and drug abuse.

19. Type S charges for hospice services.

20. Type T charges for education and training if it will promote the patient to a lower level of medical/nursing care.

21. Type U charges for surgical and medical procedures performed by a podiatrist.

22. Type V charges for transplants.

23. Type W charges for services rendered by a physician or other provider.

(D) If covered charges provide for rental of durable equipment and the participant's condition is such that use of the equipment is projected for a period of time to make purchase of the equipment less costly than rental, then with the advanced authorization by the claims administrator or his/her designee, the equipment may be purchased and the purchase price will be considered a covered charge. At the option of the claims administrator, or his/her designee, durable equipment may be purchased based on quality and cost considerations. Maintenance and repair of purchased equipment is covered if provider supplies statement of continued medical necessity in time intervals determined by claims administrator or his/her designee.

*AUTHORITY: section 103.059, RSMo 1994. \* Emergency rule filed Dec. 16, 1993,*

*effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998.*

*\*Original authority 1992.*

**22 CSR 10-2.060 Indemnity Plan Limitations**

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

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services or supplies which do not come within the definition of covered charges, or any of the following:

(A) If outpatient surgical procedures identified in 22 CSR 10-2.040(7)(A) are not pre-certified, reimbursement will be made at fifty percent (50%) of reasonable and customary charges;

(B) Blood or plasma to the extent a refund or credit is made as a result of operation of a group blood bank or otherwise;

(C) Cosmetic, plastic, reconstructive or restorative surgery performed for the purpose of improving appearance unless such expenses are incurred for repair of a disfigurement caused from any of the following:

1. An accidental injury which was sustained while covered under these rules;

2. A sickness first manifested while covered under these rules;

3. Any other accidental injury or sickness but only for expenses incurred after this coverage has been in force for at least twelve (12) months; or

4. A birth defect;

(D) Hearing aids and the fitting, eye refractions and glasses, contact lenses or their fitting of eye glasses or contact lenses (other than the first pair of contact lenses or eye glasses or the fitting after cataract surgery

which is performed while covered under these rules);

(E) Injury or sickness resulting from—

1. Act of war (declared or undeclared);
2. Insurrection; or
3. Atomic explosion or other release of nuclear energy under any condition except when used solely as medical treatment;

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

1. A plan or program operated by a national government or one of its agencies; or
2. Any state's cash sickness or similar law including any group insurance policy approved under such law;

(G) Medical care and supplies for which—

1. No charge is made;
2. The member or dependent is not required to pay, including but not limited to, any portion of any charges that are discounted; and
3. Charges exceed the usual, customary, and reasonable rate;

(H) To the extent provided by law, intentionally self-inflicted injury or illness, or injury or sickness resulting from taking part in the commission of a felony;

(I) Sickness or injury covered by Workers' Compensation, occupational disease law or similar laws, or injury if it arises out of any employment for pay, profit or gain and is covered by one of the former programs including all charges to be covered by any associated settlement agreement;

(J) Charges made with respect to a participant, but which are incurred due to the injury or sickness of a different person who is not a participant in this plan;

(K) Oral care and supplies which are used to change vertical dimension or closure, including but not limited to:

1. Procedures used for diagnosis;
2. Procedures used for balance;
3. Restoration;
4. Fixed devices; and
5. Movable devices;

(L) Any treatment or examination of teeth or nerves connected to teeth except—

1. Extraction of bony and partial bony impactions; and
2. Treatment or examination of injuries to sound and natural teeth sustained in an accident while covered under the rule, or such treatment received after the patient has been covered under the plan for at least twelve (12) consecutive months; and provided the injury/illness was incurred within one (1) year of the effective date of coverage;

(M) Except as may otherwise be specifically provided, expenses for equipment, services or supplies for any of the following,

regardless of whether or not prescribed by a physician or provider:

1. Experimental/investigational procedures, as defined in the claims administrator's guidelines;
2. Exercise for the eyes;
3. Psychological testing;
4. Nerve stimulators with the exception of transcutaneous electrical nerve simulator (TENS) units;
5. Any treatment of obesity due solely to overeating;
6. Custodial care;
7. *In vitro* and *in vivo* artificial insemination;
8. Travel, lodging, recreation or exercise;
9. Air conditioners, purifiers or humidifiers;
10. Nonprescription drug items (except insulin and other diabetic supplies); and
11. Acupuncture, acupressure, and biofeedback;

(N) Trimming of corns, calluses and toenails unless the participant is a diabetic, has a peripheral vascular disease or is blind;

(O) Foot support unless custom-made to fit the participant's foot and prescribed by a physician;

(P) Abortion except when two (2) physicians have found and so certified in writing to the claims administrator that, on the basis of their professional judgment, the life of the mother would be endangered if the fetus were carried to term or that medical complications have arisen from a previous abortion.

1. The certification must contain a diagnosis of the disease, the clinical effect of the pregnancy on the disease with the physician's prognosis of the health of the patient as affected if the fetus were carried to term, the name and address of the patient and the names of any physicians or providers previously consulted by the patient with regard to the disease and the pregnancy.

2. At least one (1) of the two (2) physicians must also certify that s/he is not an interested physician. For purposes in this rule, an interested physician is one—

A. Whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or

B. Who is the spouse or another relative who lives with a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion;

(Q) Preexisting conditions, except charges incurred after the individual has been a participant for six (6) consecutive months. A preexisting condition is one for which medical care was received or prescribed drugs were taken, or for which expenses were

incurred during the three (3) months prior to the participant's effective date. This limitation does not apply to participants transferred from another plan as provided in 22 CSR 10-2.010(1)(M)2. or 22 CSR 10-2.020(1)(A)4.;

(R) Alcohol and drug abuse treatments are limited to two (2) inpatient treatments per lifetime, the copayment does not apply to the out-of-pocket maximum and there is a lifetime maximum of fifty thousand dollars (\$50,000).

1. Network provider—up to thirty (30) days per calendar year paid at ninety percent (90%). In addition to three hundred dollar (\$300)-medical deductible, there is also a one hundred dollar (\$100) per day deductible for up to five (5) days.

2. Non-network provider—up to thirty (30) days per calendar year paid at seventy percent (70%). In addition to three hundred dollar (\$300)-medical deductible, there is also a one hundred fifty dollar (\$150)-deductible for up to five (5) days;

(S) Inpatient mental illness services are limited to thirty (30) days per year, and the copayment does not apply to the out-of-pocket maximum.

1. Network provider—paid at ninety percent (90%).

2. Non-network provider—paid at seventy percent (70%).

3. Partial day treatment—included acute day treatment and partial hospitalization. Treated as one-half (1/2) inpatient day toward thirty (30)-day maximum.

A. Network provider—paid at ninety percent (90%).

B. Non-network provider—paid at seventy percent (70%);

(T) Outpatient mental illness services are limited to fifty (50) visits per year. The copayment does not apply to the out-of-pocket maximum.

1. Network provider.

A. First five (5) visits paid at ninety percent (90%).

B. Visit six through twenty (6–20) paid at seventy percent (70%).

C. Visit twenty-one through fifty (21–50) paid at fifty percent (50%).

2. Non-network provider.

A. First five (5) visits paid at seventy percent (70%).

B. Visit six through twenty (6–20) paid at fifty percent (50%).

C. Visit twenty-one through fifty (21–50) paid at fifty percent (50%).

3. Intensive outpatient services.

A. Network provider paid at ninety percent (90%).

B. Non-network provider paid at seventy percent (70%);

(U) Marital and family counseling for group or individual psychotherapy;

(V) Chiropractic services are limited to a maximum allowable charge of fifty dollars (\$50) per visit, and a two thousand-dollar (\$2,000) total annual maximum. Diagnostic lab and X-ray services are not included in fifty dollar (\$50) maximum per visit, but are included in two thousand-dollar (\$2,000) total annual maximum;

(W) Associated charges for noncovered services;

(X) Any services not specifically included as a covered benefit;

(Y) Vitamins and nutrient supplements, except prescription prenatal vitamins, vitamin B<sub>12</sub> shots, and certain vitamin therapies as determined by the claims administrator;

(Z) Treatment of temporal mandibular joint dysfunction (TMJ) will be covered under the plan up to maximum reimbursement of five hundred dollars (\$500) per lifetime;

(AA) Reversals of tubal ligations and vasectomies;

(BB) Cardiac rehabilitation treatments are limited to thirty-six (36) visits per calendar year;

(CC) X-ray and office charges associated with flat feet;

(DD) Preferred Provider Organization (PPO) office visit copayments; and

(EE) Transplants are limited to heart, lung, liver, kidney, cornea and bone marrow, and are subject to medical necessity and effectiveness criteria and payment levels as determined by the claims administrator's guidelines. Benefits are limited to one hundred fifty thousand dollars (\$150,000) for services associated with the admission of the actual organ transplant with remainder of transplant cost applied to one (1) million dollar lifetime maximum.

(FF) Skilled nursing charges limited to one hundred twenty (120) days per calendar year.

*AUTHORITY: section 103.059, RSMo 1994. \* Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amend-*

*ment filed Nov. 25, 1997, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999.*

*\*Original authority 1992.*

**22 CSR 10-2.063 HMO/POS/POS98 Summary of Medical Benefits**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to benefit provisions and covered charges for participation in the HMO and POS plans under the Missouri Consolidated Health Care Plan.*

(1) Covered Charges.

(A) Allergy Injections—Ten dollar (\$10) copayment for office visit also covers injection. Five dollar (\$5) copayment per injection received if not during office visit.

(B) Ambulance Service—Ground services covered at one hundred percent (100%) if medically necessary or with prior approval. Air services covered at one hundred percent (100%) in emergency cases or with prior approval.

(C) Chiropractic Benefits.

1. Health Maintenance Organization (HMO) and Point of Service (POS) in-network—Charges are covered if services are accessed through the HMO or POS network provisions.

2. POS—Out-of-network coverage subject to deductible and coinsurance with the same limitations as under the indemnity plan.

(D) Contraceptives—Oral contraceptives covered at one hundred percent (100%). Oral contraceptives are not subject to coinsurance or copayments, except if obtained out-of-network for POS98.

(E) Dental Care—Treatment to reduce trauma as a result of accidental injury.

(F) Durable Medical Equipment—Twenty percent (20%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(G) Emergency Care—Fifty dollar (\$50) copayment in or out of service area. Waived if admitted.

(H) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a ten-dollar (\$10) copayment.

(I) Hearing Aids and Testing—Covered once every two (2) years, subject to twenty percent (20%) copayment and ten dollar (\$10) copayment for annual hearing test.

POS out-of-network subject to in-network amounts. POS98 out-of-network not covered.

(J) Home Health Care—Covered when authorized by HMO or POS physician. POS98 limited to sixty (60) annual visits.

(K) Hospice Care—Covered at same level as applicable benefit (that is, office visit—ten dollar (\$10) copayment, hospital provided in full).

(L) Hospital Benefit for Mental and Nervous Disorder—Twenty percent (20%) coinsurance. Hospitalization for mental health and alcohol and drug abuse limited to combined thirty (30) days per year. Partial hospitalization may be provided on a two (2) for one (1) exchange (that is any combination of sixty (60) partial days and/or thirty (30) inpatient days).

(M) Hospital Benefits for Alcohol and Drug Abuse—Same as for mental and nervous disorder above.

(N) Hospital Room and Board—Provided in full. Must be arranged by HMO or POS physician.

(O) Injections—All injections provided in full (except allergy injections).

(P) Infertility—Coverage limited to fifty percent (50%) for *in vivo* services, including provider and prescription drug charges. Exclusions include reversals of voluntary sterilization, *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). POS98 out-of-network not covered.

(Q) Maternity Coverage—Ten dollar (\$10) copayment for initial visit. All other prenatal visits, delivery costs and routine postnatal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitations allowed.

(R) Oral Surgery—When medically necessary.

(S) Organ Transplants—The following organ transplants covered at one hundred percent (100%): bone marrow, cornea, kidney, liver, heart and lung when: 1) neither experimental nor investigational, and 2) medically necessary as determined by HMO or POS. Donor expenses are covered as long as the patient is a member of the HMO or POS. No waiting periods allowed. POS/POS98 out-of-network limited to in-network rates.

(T) Outpatient Diagnostic Lab and X-Ray—Provided in full.

(U) Outpatient Mental and Nervous Disorder—Ten dollar (\$10) copayment per visit. Maximum twenty (20) visits per year. Group therapy may be provided on a two (2) for one (1) exchange (i.e. any combination of forty (40) group sessions and/or twenty (20) individual sessions). POS98 subject to 50 visits per year for in-network and 25 visits per year

for out-of-network. Deductible and coinsurance do not apply to out-of-pocket maximum for out-of-network services.

(V) Oxygen—Subject to twenty percent (20%) coinsurance. Covered under Durable Medical Equipment.

(W) Physical Therapy and Rehabilitation Services—Five dollar (\$5) copayment per visit for outpatient therapy. Provides short-term (significant improvement of condition within two (2) months) physical, speech, and/or occupational therapy and rehabilitation services for inpatient and outpatient per incident.

(X) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after ten dollar (\$10) copayment per visit.

(Y) Plan Maximum—Not applicable for HMO/POS. POS98 out-of-network subject to one (1) million dollars with five thousand dollars (\$5,000) annual reinstatement.

(Z) Prescription Drugs—Maximum thirty (30)-day supply, five dollar (\$5) copayment. Insulin, syringes, test strips and glucometers are included in this coverage. Additional restrictions may apply for use of nonformulary medication with HMO/POS. POS98 lessor of twenty dollar (\$20) copayment or cost of drug for nonformulary drug.

(AA) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well-woman exam without referral to a network provider.

(BB) Prosthetics—POS98 (only) coverage for repair or replacement due to change in medical condition.

(CC) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full.

(DD) Medicare HMOs (risk contracts) will provide benefits as specified in their contract and will be administered in accordance with all applicable federal statutes and regulations.

(EE) Complications—Normally covered charges arising as a complication of a non-covered service.

*AUTHORITY: section 103.059, RSMo 1994. \* Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998.*

*Emergency amendment filed Feb. 23, 1998, effective March 5, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998.*

*\*Original authority 1992.*

## 22 CSR 10-2.067 HMO and POS Limitations

*PURPOSE: This rule establishes the policy of the board of trustees in regard to limitations in the HMO and POS plans under the Missouri Consolidated Health Care Plan.*

(1) Benefits shall not be payable for, or in connection with, any medical benefit, services or supplies which do not come within the definition of covered charges, or any of the following:

(A) Abortion services limited to situations when the life of the mother is endangered if the fetus is carried to term or due to the non-viability of the fetus;

(B) Acupuncture;

(C) Care obtained outside the HMO or POS service area which could have been anticipated prior to leaving the service area;

(D) Care received without charge, whether or not provided at a government facility;

(E) Cosmetic or reconstructive surgery, unless medically necessary to repair a functional disorder caused by disease, injury, or congenital defect;

(F) Custodial or domiciliary care;

(G) Experimental or investigational services, procedures, supplies or drugs as defined in the HMO or POS administrative guidelines;

(H) Growth hormone therapy unless authorized by the HMO or POS;

(I) Hypnosis;

(J) Injuries and illness resulting out of course of employment and covered by Workers' Compensation, occupational disease law or similar law, including all charges to be covered in any associated settlement agreement;

(K) Laetrile;

(L) Liability to provide services limited to the maximum capability of the HMO or POS in the event of major disaster, epidemic, war, riot, or other circumstances beyond the control of the HMO or POS;

(M) No coverage will be provided to the following procedures:

1. Reversal of voluntary sterilization;

2. *In vitro* fertilization;

3. Gamete intrafallopian transfer (GIFT); and

4. Zygote intrafallopian transfer (ZIFT);

(N) Nongrowth related replacement of prosthetics (HMO, POS only);

(O) Orthoptics;

(P) Over-the-counter medications, except insulin;

(Q) Personal comfort items;

(R) Physical examinations or immunizations requested by a third party;

(S) Physical fitness equipment;

(T) Private duty nursing unless authorized by the HMO or POS;

(U) Services not deemed to be medically necessary;

(V) Services not provided by an HMO contracted physician or provider unless prior approval received from the HMO;

(W) Services provided by family or household members;

(X) Smoking cessation patches and gum;

(Y) Storage of whole blood, blood plasma, and blood products;

(Z) Transsexual surgery;

(AA) Travel and transportation expenses except those specifically listed under the covered benefits;

(BB) Treatment of military service-connected injury and illness;

(CC) Treatment for obesity unless deemed medically necessary, including surgery, food supplements, behavior modification programs, and diet planning services;

(DD) Treatment for temporal mandibular joint (TMJ) dysfunction;

(EE) Trimming of nails, corns or calluses except for persons being treated for diabetes or peripheral vascular disease;

(FF) Out-of-network services without the proper referrals in an HMO are not covered services;

(GG) Out-of-network services in a POS are subject to reimbursement levels based upon the limited indemnity plan (three hundred dollar (\$300) deductible and seventy/thirty percent (70/30%) coinsurance); and

(HH) All limitations for individuals with Medicare HMOs (risk contracts) will be applied as specified in their respective contracts and in compliance with all applicable federal statutes and regulations.

*AUTHORITY: section 103.059, RSMo 1994. \* Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997.*

*Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999.*

*\*Original authority 1992.*

**22 CSR 10-2.070 Coordination of Benefits**

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

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

(2) As used in this rule—

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

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

(B) The definition of plan shall not include:

1. Hospital indemnity-type plans;
2. Types of plans for students; or
3. Any individual policy or plan;

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

(D) Allowable expense means a necessary, reasonable and customary item of medical, vision, dental or health expense which is covered at least in part under one (1) of the plans. If a plan provides benefits in the form of services, the cash value of such service will be deemed to be the benefit paid. An allowable expense to a secondary plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

mined before the benefits of the plan which covers the child as a dependent of the parent without custody;

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

C. In spite of subparagraphs (3)(D)2.

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

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

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

(5) If a member is eligible for Medicare due to a disability, Medicare is the primary plan and this plan is a secondary plan. If a member or dependent is eligible for Medicare due to end stage renal disease, this plan is primary for the first eighteen (18) months. Medicare is primary after the first eighteen (18) months.

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

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

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

(A) Any person to whom, for whom or with respect to whom these payments were made;

(B) Any insurance company; or

(C) Any other organization.

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

(10) If one (1) of the other plans involved (as defined in coordination of benefits provision) provides benefits on an excess insurance or excess coverage basis, subsections (3)(C) and (D) shall not apply to the plan and this policy will pay as excess coverage.

*AUTHORITY: section 103.059, RSMo 1994. \* Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995.*

*\*Original authority 1992.*

## 22 CSR 10-2.075 Review and Appeals Procedure

*PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participants in the Missouri Consolidated Health Care Plan.*

(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

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

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

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

(5) All insured members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the HMO, POS or Indemnity health plan contract applicable to the insured member. Only after these procedures have been exhausted may the insured appeal to the MCHCP board of trustees to review the decision of the health plan contractor.

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

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

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

1. The hearing will be scheduled by the MCHCP.

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

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

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.

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

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

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

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

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

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

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

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

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

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

*AUTHORITY: section 103.059, RSMo 1994. \* Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1,*



1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998.

\*Original authority 1992.

**22 CSR 10-2.080 Miscellaneous Provisions**

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

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

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

(3) Confidentiality of Records. The health records of the participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to

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

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

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

*AUTHORITY: section 103.059, RSMo 1994.\* Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan.*

1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997.

\*Original authority 1992.