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

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
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22 CSR 10-3.010 Definitions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.

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

(1) Accident. An unforeseen and unavoidable event resulting in an injury which is not due to any fault or misconduct on the part of the person injured.

(2) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

(3) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

(4) Adverse determination. When the claims administrator reviews an admission, availability of care, continued stay, or other health care service and decides that it is not medically necessary, appropriate, or effective. Therefore, payment for the requested service is denied, reduced, or terminated.

(5) Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible and coinsurance amounts.

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

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

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

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

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

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

(10) Benefits. Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

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

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

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

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

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

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

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

(18) Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

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

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

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

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

(23) Copayment. A set dollar amount that the covered individual must pay for specific services.

(24) Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury.

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

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

(27) Date of service. Date medical services are received.

(28) Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

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

(A) Stepchild;

(B) Foster child;

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

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

1. Except for a disabled child as described in 22 CSR 10-3.010(88), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26).

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

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

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

(32) Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

(33) Disease management. A program offered to non-Medicare members to help manage certain chronic diseases.

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

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

(A) Doctor of medicine;

(B) Doctor of osteopathy;

(C) Podiatrist;

(D) Optometrist;

(E) Chiropractor;

(F) Psychiatrist;

(G) Psychologist;

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

(I) Doctor of dentistry; or

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

(36) Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

(37) Eligibility date. As described in 22 CSR 10-3.020.

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

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

(B) Serious impairment to a bodily function;

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

(D) Inadequately controlled pain; or

(E) Situations when the health of a pregnant woman or her unborn child are threatened.

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

(40) Emergency Services. With respect to an emergency medical condition—

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

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

(41) Employee. A person employed by a participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity.

(42) Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent except as noted in 22 CSR 10-3.030(1)(A)7.

(43) Employer. The public entity that employs the eligible employee as defined above.

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

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

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

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

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

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

(F) Prescription drugs;

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

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

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

(J) Pediatric services, including oral and vision care—routine vision exam, dental

care/accidental injury, immunizations, preventive services, and newborn screenings.

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

(46) Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below is considered experimental/investigational/unproven and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion—

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

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

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

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

(48) Formulary. A list of drugs covered by the pharmacy benefit manager and as allowed by the plan administrator.

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

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

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

(52) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.

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

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

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

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

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

(58) Hospital.

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

(B) An institution not meeting all the requirements of subsection (58)(A) above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

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

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

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

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

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

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

(61) Infertility. Any medical condition causing the inability or diminished ability to reproduce.

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

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

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

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

(66) Lifetime. The period of time a member or the member's eligible dependents participate in the plan.

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

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

(69) myMCHCP. A secure MCHCP member website that includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites.

(70) Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.

(71) Medically necessary. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion—

(A) Are expected to be of clear clinical benefit to the patient;

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

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

(73) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

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

(75) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.

(76) Non-network provider or non-participating provider. Any physician, hospital, pharmacy, or other health provider that does not have a contract with the plan or its designee.

(77) Nurse. A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

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

(79) Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

(80) Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

(81) Out-of-pocket maximum. The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.

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

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

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

(85) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

(86) Participant. Any employee or dependent accepted for membership in the plan.

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

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

(89) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope

of his/her practice, as licensed under section 334.021, RSMo.

(90) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

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

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

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

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

(95) Preventive service. A procedure intended for avoidance or early detection of an illness.

(96) Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with a medical plan.

(97) Prior authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.

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

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

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

(101) Proof of prior coverage. If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and

(C) List of dependents covered.

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

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

(104) Provider. A physician, hospital, medical agency, specialist, or other duly-licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(35). Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

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

(C) Certified Nurse Midwife (CNM)—when acting within the scope of their license in the state in which they practice and performing a service which would be payable under this plan when performed by a physician;

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

(E) Licensed Clinical Social Worker;

(F) Licensed Professional Counselor (LPC);

(G) Licensed Psychologist (LP);

(H) Nurse Practitioner (NP);

(I) Physicians Assistant (PA);

(J) Qualified Occupational Therapist;

(K) Qualified Physical Therapist;

(L) Qualified Speech Therapist;

(M) Registered Nurse Anesthetist (CRNA);

(N) Registered Nurse Practitioner (ARNP); or

(O) Therapist with a PhD or Master's Degree in Psychiatry or related field.

(105) Provider directory. A listing of network providers within a health plan.

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

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

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

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

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

(111) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multidisciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care, and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission

for the Accreditation of Rehabilitation Facilities.

(112) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(6)(B) and is currently receiving a monthly retirement benefit from a public entity.

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

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

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

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

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

(D) A daily medical record for each patient;

(E) Transfer arrangements with a hospital; and

(F) A utilization review plan.

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

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

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

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

(118) State. Missouri.

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

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

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

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

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

(124) Survivor. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(A).

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

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

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

(128) Usual, Customary, and Reasonable charge.

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

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

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

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

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

(130) Vendor. The current applicable third-party administrator of MCHCP benefits.

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated March 7, 2011. Emergency amendment filed Feb. 25, 2011, effective March 7, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions

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

(1) The participant's initial application, any subsequently accepted modifications to such application, the handbook, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any other written materials interpreting the subscriber agreement for the benefit of members and administrators are

not part of the subscriber agreement.

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

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

2. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the prior plan may be credited for those joining one (1) of the preferred provider organization (PPO) options. Appropriate proof of said deductibles will be required.

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

(3) The effective date of participation shall be determined, subject to the effective date provision in subsection (3)(C), as follows:

(A) Employee Participation.

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

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date the application is received, 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 one (1) of the following occurs:

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

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. Application must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case application for coverage through the plan must be made within sixty (60) days of the loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a child is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the application. Application for participants must be made in accordance with the following provisions:

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

2. 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;

3. 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

4. Survivors, retirees, vested subscribers, and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage, except when a dependent's employer-sponsored coverage ends due to one (1) of the following:

A. Termination of employment;

B. Retirement; and

C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) Effective Date Provision.

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

(D) Application for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's:

1. Employer-sponsored medical plan terminates or coverage by the employer is no longer offered;

2. The employer contributions toward the premiums cease; or

3. A dependent no longer qualifies due to age;

(E) Application may be made for dependent coverage within sixty (60) days of the event—

1. A Qualified Medical Child Support Order is received;

2. A dependent no longer qualifies for Medicaid; or

(F) Application may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.

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

(A) Written request by the employee;

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

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

(D) Termination of Eligibility for Participation.

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

(5) and (6).

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

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (6).

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

(6) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if the active employee was vested and eligible for a future retirement benefit and eligible dependents meet one (1) of the following conditions:

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

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

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

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

1. Eligibility Criteria:

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

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

C. Coverage since first eligible;

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

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

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

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

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

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers, and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in paragraph (6)(B)4.; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the retirement system of the participating public entity when s/he reaches retirement age. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (4)(C). Coverage may be reinstated upon return from military leave. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

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

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (subscriber only or subscriber 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 (subscriber only or subscriber and dependents) upon returning to employment.

(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. 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.

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

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

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

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

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

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

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

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

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

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

(8) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) if: a) The member continues and maintains coverage under the thirty-six (36)-month provision of COBRA; and b) The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Public Entity Membership Agreement and Participation Period of the Missouri Consolidated Health Care Plan.

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

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

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

2. The public entity shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

3. For public entities with less than twenty-five (25) employees, the public entity shall only offer one (1) plan choice to its employees. For public entities with twenty-five (25) or more employees, the public entity may offer two (2) plans provided by MCHCP;

4. For public entities with more than a total of three (3) employees, at least seventy-five percent (75%) of all eligible employees must join the MCHCP;

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

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

7. 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

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

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

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

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

(2) The public entity's participation period shall begin on the date specified in the participation agreement. Participation shall continue

until the end of the participation agreement is reached or immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-3.080(1).

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

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

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

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

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Jan. 4, 2010, effective June 30, 2010.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

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

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

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

A. Ambulance services for non-emergency use whether air or ground;

B. Applied behavioral analysis for autism;

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

D. Chiropractic services after twenty-six (26) visits annually;

E. Cochlear implant device;

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

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

H. Genetic testing or counseling;

I. Home health care and palliative services;

J. Hospice care;

K. Hospital inpatient services except for observation stays;

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

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

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

O. Oxygen provided on an outpatient basis;

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

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

R. Skilled nursing facility;

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

T. Transplants including requests related to covered travel and lodging.

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

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

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

C. Medications that may be prescribed for several conditions including some where treatment is not medically necessary;

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

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

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

3. Prior authorization time frames.

A. A benefit determination for nonurgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the

member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

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

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

(C) Retrospective Review—Reviews conducted after services have been provided to a patient. The retrospective review includes an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment.

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges
(Rescinded June 30, 2011)

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency rescission filed Dec. 20, 2010, effective Jan. 1, 2011, expired June 29, 2011. Rescinded: Filed Dec. 20, 2010, effective June 30, 2011.

22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges
(Rescinded June 30, 2011)

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency rescission filed Dec. 21, 2010, effective Jan. 1, 2011, expired June 29, 2011. Rescinded: Filed Dec. 21, 2010, effective June 30, 2011.

22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges
(Rescinded June 30, 2011)

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22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars ($1,000); family limit each calendar year, three thousand dollars ($3,000). Non-network: per individual each calendar year, two thousand dollars ($2,000); family limit each calendar year, six thousand dollars ($6,000).

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

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

(C) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

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

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

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

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

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

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; Non-network: seventy percent (70%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

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

(A) Network out-of-pocket maximum for individual—four thousand five hundred dollars ($4,500).

(B) Network out-of-pocket maximum for family—thirteen thousand five hundred dollars ($13,500).

(C) Non-network out-of-pocket maximum for individual—ten thousand dollars ($10,000).

(D) Non-network out-of-pocket maximum for family—thirty thousand dollars ($30,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 2000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars ($2,000); family limit each calendar year, six thousand dollars ($6,000). Non-network: per individual each calendar year, four thousand dollars ($4,000); family limit each calendar year, twelve thousand dollars ($12,000).

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

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

(C) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

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

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

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

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

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

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty-five dollars ($25), specialist—thirty-five dollars ($35); Non-network: sixty percent (60%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty-five dollars ($25) for initial visit, specialist—thirty-five dollars ($35) for initial visit; Non-network: sixty percent (60%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

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

(A) Network out-of-pocket maximum for individual—six thousand dollars ($6,000).

(B) Network out-of-pocket maximum for family—eighteen thousand dollars ($18,000).

(C) Non-network out-of-pocket maximum for individual—twelve thousand dollars ($12,000).

(D) Non-network out-of-pocket maximum for family—thirty-six thousand dollars ($36,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges

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

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars ($1,200); family limit each calendar year, two thousand four hundred dollars ($2,400). Non-network: per individual each calendar year, two thousand four hundred dollars ($2,400); family limit each calendar year, four thousand eight hundred dollars ($4,800).

(A) The family deductible must be met before claim payments begin, applicable when two (2) or more family members are covered.

(B) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible

and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital.

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

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

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

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

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

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at sixty percent (60%) coinsurance after the deductible.

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

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

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

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

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

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

(5) Pharmacy benefits are subject to the High Deductible Health Plan (HDHP) deductible and coinsurance.

(6) A member does not qualify for the HDHP if they are covered under or enrolled in any of the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

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

(D) Health reimbursement account (HRA); or

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

(7) A member may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

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

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

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges

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

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

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

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

(C) During a hospital admission for delivery, only the mother's claims will be subject to deductible and coinsurance. The newborn will not be subject to a separate deductible and coinsurance. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital.

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

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

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

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

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

(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.

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

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

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

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

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

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the usual, customary, and reasonable limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges

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

(1) Benefit Provisions Applicable to the PPO 600, PPO 1000, PPO 2000, and High Deductible Health Plan (HDHP) Plans. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a participant while covered under the plans, provided the deductible requirement, if any, is met.

(2) Covered Charges Applicable to the PPO 600, PPO 1000, PPO 2000, and HDHP Plans.

(A) Only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a noncovered service, and which are—

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;

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

3. Not excluded by the limitations; and

4. For not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

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

1. The medical benefits or supplies usually rendered or prescribed for the condition; and

2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

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

(D) Plan benefits for the PPO 600, PPO 1000, PPO 2000, and HDHP Plans are as follows:

PUBLIC ENTITY BENEFITS
Allergy Serum Multi-dose vial No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers or air ventilation system cleaning.
Ambulance Service Non-emergency air or ground excluded unless prior authorization received from medical plan. Use of air ambulance or medical helicopter service from any continent returning to the U.S. is excluded.
Applied Behavioral Analysis for Autism For children younger than age 19 The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of observation, measurement and functional analysis of the relationship between environment and behavior. $40,000 annual limit. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Prior authorization by medical plan required.
Birth Control Prescriptions
Birth Control Devices and Injections Administered in the physician's office.
Cardiac and Pulmonary Rehabilitation Up to 36 visits within a 12-week period per incident Prior authorization by medical plan required after 36 visits within a 12-week period.
Chelation Therapy Limited to treatment of lead poisoning in children as recommended by Missouri Department of Health and Senior Services.
Chiropractic Services Up to 26 visits annually Prior authorization by medical plan required after 26 visits annually.
Cochlear Implant Device Prior authorization by medical plan required.
Colonoscopy
Convenient Care Clinic (CCC)

Dental Care/Accidental Injury Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors or cysts. Treatment must be initiated within 60 days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Prior authorization by medical plan required.
Durable Medical Equipment (DME)/Medically Necessary Disposable Supplies Basic equipment that meets medical needs. DME includes, but is not limited to, augmentative communication devices and manual and powered mobility devices. Includes repair and replacement due to normal wear and tear, if there is a change in medical condition or if growth-related. Disposable supplies that do not withstand prolonged use and are periodically replaced include, but are not limited to, colostomy and ureterostomy bags and prescription compression stockings. No coverage for non-reusable disposable supplies including but not limited to bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies including oral appliances. Prior authorization by medical plan required for durable medical equipment over $1,500 and/or rentals over $500/month. Prescription compression stockings are limited to two pairs or four individual stockings per plan year.
Emergency Room Services If admitted to hospital, may be required to transfer to network facility for maximum benefit. Paid as network benefit.
Enteral Feedings (Tube Feeding) Nutritional supplements that are prescribed by a physician and administered through enteral feedings, provided they are the sole source of nutrition and the member has a permanent condition, or partial nutrition during transition. This includes nutritional and electrolyte supplements and supplies related to enteral feedings (for example, feeding tubes, pumps and other materials used to administer enteral feedings).
Flu Shot/Nasal Spray (FluMist®) Covered at 100% when administered in a network physician's office. When shot is obtained elsewhere, the member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive reimbursement up to $25. Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

Genetic Testing or Counseling Genetic testing or counseling as part of treatment for a medical condition No coverage for testing based on family history. Prior authorization by medical plan required.
Hair Analysis and Prostheses Limited to prostheses and expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or alopecia totalis for children 18 years of age or younger. Annual maximum $200. Lifetime maximum $3,200. No coverage for services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.
Hearing Aids (Per Ear) Covered once every two years. Member pays coinsurance amount per hearing aid. If hearing aid cost exceeds the amount listed below, member is also responsible for charges over that amount. Conventional: $1,000 Programmable: $2,000 Digital: $2,500 BAHA: $3,500
Hearing Testing One hearing test per year. Additional hearing tests are covered if recommended by physician.
Home Health Care/Palliative Services Prior authorization by medical plan required.
Hospice Care Inpatient or Outpatient Includes bereavement and respite care. Prior authorization by medical plan required.
Hospital Benefits - Inpatient Room and Board Based on semi-private room • Medical (including outpatient services) • Mental Health (including outpatient services) • Chemical Dependency (including outpatient services) • Observation for Medical, Mental Health or Chemical Dependency Except for observation, prior authorization by medical plan required.

Immunizations (Age-appropriate Adult and Pediatric) Specified schedule of immunizations including, but not limited to, polio, rubella, measles, mumps, tetanus, whooping cough, diphtheria, hepatitis A and B, haemophilus influenzae type B (Hib), human papillomavirus, shingles, chicken pox, meningitis and pneumonia. Not covered when requested by third party or for travel. Immunizations required by the Missouri Department of Health and Senior Services or recommended by the Centers for Disease Control and Prevention.
Injections and Infusions Administered in the physician's office.
Lab and X-ray
Mammograms One mammogram per year. Additional mammograms are covered if recommended by physician.
Mastectomies No time frame on receiving reconstructive surgery or prostheses after mastectomies necessary to restore symmetry, as recommended by physician.
Maternity Coverage Newborns and their mothers are allowed hospital stays of at least 48 hours after normal birth and 96 hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two-visit minimum, at least one in the home. Prior authorization by medical plan required for maternity stays longer than 48 hours (normal delivery) or 96 hours (C-section).
Mental Health/Chemical Dependency (Office Visit)
Nutrient Supplements Formula and low-protein modified food products recommended by physician and limited only to treatment of Phenylketonuria (PKU) or any inherited disease of amino and organic acids
Nutritional Counseling Up to three sessions annually with registered dietitian, not limited by diagnosis. Up to three additional sessions considered with referral and medical diagnosis. Prior authorization by medical plan required after three sessions annually.
Office Visit Primary Care Physicians Specialists

Orthotics

Therapeutic Shoes for Diabetics

Therapeutic shoes, inserts, and/or modifications to therapeutic shoes are covered if the following criteria are met:

- The patient has diabetes mellitus; and
- The patient has one or more of the following conditions:
  - Previous amputation of the other foot, or part of either foot, or
  - History of previous foot ulceration of either foot, or
  - History of pre-ulcerative calluses of either foot, or
  - Peripheral neuropathy with evidence of callus formation of either foot, or
  - Foot deformity of either foot, or
  - Poor circulation in either foot; and
- The certifying physician who is managing the patient's systemic diabetes condition has certified that indications noted in this *Therapeutic Shoes for Diabetics* section are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

For adult patients meeting these criteria, coverage is limited to one of the following within one year:

- One pair of custom molded shoes (which includes inserts provided with these shoes) and 2 additional pairs of inserts; or
- One pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes).

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom molded shoes. See Orthopedic Footwear benefit. There is no separate payment for the fitting of the shoes, inserts, or modifications or for the certification of need or prescription of the footwear.

Spinal Orthoses

A thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

Helmets

Helmets are provided when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living. These devices are not provided for use during sports-related activities.

Cranial Orthosis for Plagiocephaly

Plagiocephaly describes an asymmetrically shaped head. Synostotic plagiocephaly (craniosynostosis) is due to the premature closure of the cranial sutures. In non-synostotic plagiocephaly, also referred to as positional or deformational, the cranial sutures remain open. Cranial orthosis is the use of a special helmet or band on the head, which aids in molding the shape of the cranium to normal.

Dynamic orthotic cranioplasty, which may also be referred to as cranial molding, molding helmet, cranial banding, or cranial orthosis, is considered medically necessary only as an adjunct to operative therapy following surgery for craniosynostosis. Molding helmet therapy, including dynamic orthotic cranioplasty, is not a covered benefit for the non-operative management of positional or non-synotic plagiocephaly.
Initial reimbursement shall cover any subsequent revisions.

Cervical Orthoses

A cervical orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the neck; or
- To facilitate healing following an injury to the cervical spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the cervical spine or related soft tissue; or
- To otherwise support weak cervical muscles and/or a deformed cervical spine.

Hip Orthoses

A hip orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the hip; or
- To facilitate healing following an injury to the hip or related soft tissues; or
- To facilitate healing following a surgical procedure on the hip or related soft tissue; or
- To otherwise support weak hip muscles and/or a hip deformity.

Knee Orthoses

A knee orthosis is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the knee; or
- To facilitate healing following an injury to the knee or related soft tissues; or
- To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- To otherwise support weak knee muscles and/or a knee deformity.

These devices are not provided solely for use during sports-related activities.

Ankle–Foot/Knee–Ankle–Foot (AFO) Orthoses

AFOs Not Used During Ambulation

A static AFO is covered if the following criteria are met:

- Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); and,
- Reasonable expectation of the ability to correct the contracture; and,
- Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and,
- Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; OR
- The patient has plantar fasciitis.

If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff or caregiver. A static AFO and replacement interface will be denied as not medically necessary if the contracture is fixed. A static AFO and replacement interface will be denied as not medically necessary for a patient with a foot drop but without an ankle flexion contracture. A component of a static AFO that is used to address positioning of the knee or hip will be denied as not

medically necessary because the effectiveness of this type of component is not established.

If a static AFO is covered, a replacement interface is covered as long as the patient continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not medically necessary.

A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities.

AFOs and KAFOs Used During Ambulation

AFOs are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

Knee–ankle–foot orthoses (KAFO) are covered for ambulatory patients for whom an ankle–foot orthosis is covered and for whom additional knee stability is required.

If the basic coverage criteria for an AFO or KAFO are not met, the orthosis will be denied as not medically necessary. AFOs and KAFOs that are molded-to-patient-model, or custom-fabricated, are covered for ambulatory patients when the basic coverage criteria listed above and one of the following criteria are met:

- The patient could not be fit with a prefabricated AFO, or
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
- There is a need to control the knee, ankle or foot in more than one plane, or
- The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
- The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

Current Procedural Terminology (CPT) L-coded additions to AFOs and KAFOs will be denied as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.

Foot Orthosis

Custom, removable foot orthoses are considered medically necessary for members who meet the following criteria:

- Member has any of the following conditions:
  - Adults (skeletally mature feet):
    - Acute plantar fasciitis
    - Acute sport-related injuries (including: diagnoses related to inflammatory problems; e.g., bursitis, tendonitis)
    - Calcaneal bursitis (acute or chronic)
    - Calcaneal spurs (heel spurs)
    - Conditions related to diabetes (see section above on therapeutic shoes for diabetes for a complete list of medically necessary diagnoses)
    - Inflammatory conditions (i.e., sesamoiditis; submetatarsal bursitis; synovitis; tenosynovitis; synovial cyst; osteomyelitis; and plantar fascial fibromatosis)
    - Medial osteoarthritis of the knee (lateral wedge insoles)
    - Musculoskeletal/arthropathic deformities (including: deformities of the joint or

skeleton that impairs walking in a normal shoe; e.g. bunions, hallux valgus, talipes deformities, pes deformities, anomalies of toes)
- Neurologically impaired feet (including: neuroma; tarsal tunnel syndrome; ganglionic cyst; and neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease)
- Vascular conditions (including: ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), chronic thrombophlebitis).

- Children (skeletally immature feet):
  - Hallux valgus deformities
  - In-toe or out-toe gait
  - Musculoskeletal weakness (e.g., pronation, pes planus)
  - Structural deformities (e.g., tarsal coalitions)
  - Torsional conditions (e.g., metatarsus adductus, tibial torsion, femoral torsion)

Orthopedic Footwear

Orthopedic footwear is covered for adults if it is an integral part of a covered leg brace. Oxford shoes are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for non-diabetics, etc., are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements, sole replacements, and shoe transfers involving shoes on a covered brace are also covered. Inserts and other shoe modifications are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace.

A shoe and related modifications, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to a brace is non-covered.

Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace.

Upper Limb Orthoses

An upper limb orthosis is covered when it is ordered for one of the following indications:
- To reduce pain by restricting mobility of the joint(s)
- To facilitate healing following an injury to the joint(s) or related soft tissues
- To facilitate healing following a surgical procedure on the joint(s) or related soft tissue

Elastic Supports

Elastic supports are covered when they are ordered for one of the following indications:
- Severe or incapacitating vascular problems, such as
  - acute thrombophlebiti
  - massive venous stasis'
  - pulmonary embolism
- Venous insufficiency
- Varicose veins
- Edema of lower extremities
- Edema of pregnancy
- Lymphedema

Trusses

Trusses are covered when a hernia is reducible with the application of a truss.

Orthotic-Related Supplies

Orthotic-related supplies are covered when the device with which it is used is covered and they are necessary for the function of the orthotic device.

Cast Boot, Post-Operative Sandal or Shoe, Healing Shoe

A cast boot or post-operative sandal or shoe is covered when it is medically necessary for one of the following indications:

- to protect a cast from damage during weight-bearing activities following injury or surgery;
- to provide appropriate support and/or weight-bearing surface to a foot following surgery;
- to promote good wound care and healing via appropriate weight distribution and foot protection; or
- when the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

Specific Exclusions

Non-covered devices and supplies include, but are not limited to, all of the following:

- Experimental or investigational devices
- Items for the patient's comfort or convenience or for the convenience of the patient's caregiver(s)
- Items to have on hand for backup or duplicates to have available at various locations
- Devices and supplies for residents of nursing facilities
- Equipment or supplies covered by another agency

Replacing Orthotic Devices

When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item. A replacement is subject to review of medical necessity. The plan will take into account the anticipated life expectancy of the device.

Prior authorization by medical plan required for orthotics over $1,000

Outpatient Diagnostic Procedures

Including, but not limited to, diagnostic sigmoidoscopies, endoscopies, sleep studies, ultrasounds, electroencephalograms (EEGs) and electrocardiograms (EKGs)

Oxygen

Outpatient

Go to DURABLE MEDICAL EQUIPMENT in this section.

Prior authorization by medical plan required.

Physical, Speech and Occupational Therapy and Rehabilitation Services - Outpatient

Up to 60 combined visits allowed per incident if showing significant improvement. Aquatic therapy must be performed by physical therapist to be covered.

Speech Therapy:

Covered as medically necessary for either of the following:

- A prescribed course of speech therapy by an appropriate healthcare provider for the

treatment of a severe impairment of speech/language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests that measure the extent of the impairment, performance deviation, and language and pragmatic skills assessment levels.

- A prescribed course of voice therapy by an appropriate healthcare provider for a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery).

When all of the following criteria are met:

- The treatment being recommended has the support of the treating physician;
- The therapy being ordered requires the one-to-one intervention and supervision of a speech-language pathologist;
- The therapy plan includes specific tests and measures that will be used to document significant progress every two weeks;
- Meaningful improvement is expected from the therapy and
- The treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance program upon discharge.

Speech or voice therapy is not covered in any of the following situations:

- Any computer-based learning program for speech or voice training purposes
- School speech programs
- Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy)
- Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs)
- Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver
- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Therapy or treatment provided to improve or enhance job, school or recreational performance
- Long-term rehabilitative services when significant therapeutic improvement is not expected

Physical Therapy:

Covered as a prescribed course of physical therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:

- The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable,

attainable treatment goals.

Physical therapy is not covered for the following:

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition
- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. occupational therapy)
- Work hardening programs
- Back school
- Vocational rehabilitation programs and any program with the primary goal of returning an individual to work
- Group physical therapy (because it is not one-on-one, individualized to the specific person's needs)
- Services for the purpose of enhancing athletic performance or for recreation

Occupational Therapy:

Covered as prescribed course of occupational therapy by an appropriate healthcare provider as medically necessary when all of the following criteria are met:

- The program is designed to improve or compensate for lost or impaired physical functions, particularly those impacting activities of daily living, resulting from illness, injury, congenital defect, or surgery;
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time and
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

Occupation Therapy is not covered for the following:

- Treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended to improve or maintain general physical condition
- Long-term rehabilitative services when significant therapeutic improvement is not expected
- Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g. physical therapy)
- Work hardening programs
- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs)
- Driving safety/driver training

Prior authorization by medical plan required after 60 combined visits per incident.

Physician Charges

Preventive Services • Services recommended by the U.S. Preventive Services Task Force (categories A and B) • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration • Preventive care and screenings for women supported by the Health Resources and Services Administration Annual physical exams (Well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam - one per calendar year Age-specific cancer screenings: • Mammograms • Pap smears • Prostate cancer screenings • Colorectal screenings • Colonoscopy and sigmoidoscopy screenings For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.
Prostheses (Prosthetic Devices) Basic equipment that meets medical needs Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related. Prior authorization by medical plan required for prostheses over $1,000.
Skilled Nursing Facility Benefits are limited to 120 days per calendar year. Prior authorization by medical plan required.

Surgery (Inpatient and Outpatient) Includes sterilization Prior authorization by medical plan required for outpatient surgeries: • Potential cosmetic surgery • Sleep Apnea surgery • Implantable Stimulators • All outpatient surgeries with procedure codes ending in T (temporary codes used for data collection, experimental, investigational or unproven surgeries) • Outpatient spinal surgeries including but not limited to artificial disc replacement, fusions, non-pulsed radiofrequency denervation, vertebroplasty/kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure. Oral surgery • Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological exams • Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth • Reduction of fractures and dislocations of the jaw • Excision of exostosis of jaws and hard palate • External incision and drainage of cellulitus • Incision of accessory sinuses, salivary glands or ducts • Frenectomy
Transplants When neither experimental nor investigational and medically necessary: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal or any combination. Includes services related to organ procurement and donor expenses if not covered under another plan. Contact medical plan for arrangements, prior authorization and transplant network.

Travel, if approved, is limited to $10,000 maximum per transplant. Network Includes travel and lodging allowance for recipient and his or her immediate family travel companion (younger than 19, both parents) if transplant facility is more than 100 miles from residence. Lodging: Maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates. Travel: IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement). Meals: Not covered. Prior authorization by medical plan required. Non-network Reimbursement limited to maximum schedule. Charges above the maximum are your responsibility and do not apply to your deductible or out-of-pocket maximum. Travel, lodging and meals not covered. Prior authorization by medical plan required.
Urgent Care Paid as network benefit.

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Limitations

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein.

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

(3) Acts of war—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

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

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy with the exception of aquatic therapy performed by a physical therapist.

(6) Assistant surgeon services—not covered unless determined to meet the clinical eligibility for coverage under the plan.

(7) Athletic trainer services—services by a licensed athletic trainer not covered.

(8) Autopsy.

(9) Bariatric procedures—not covered except for members who have undergone bariatric procedures before December 31, 2010, that were approved by the medical plan will receive follow-up care until December 31, 2011. Revisions and corrections of bariatric procedures are covered only when the revision is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscense, gastric leaking, and embolism).

(10) Blood donor expenses—not covered.

(11) Blood pressure cuffs/monitors—not covered.

(12) Blood storage—not covered, including whole blood, blood plasma, and blood products.

(13) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

(14) Care received without charge.

(15) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(16) Childbirth classes.

(17) Comfort and convenience items.

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

(19) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be provided by persons without the training of a health care provider.

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

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

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

(23) Examinations requested by a third party.

(24) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

(25) Exercise equipment.

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

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

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

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

(30) Gender reassignment—health services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.

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

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

(33) Home births.

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

(35) Infertility treatment.

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

(37) Long-term care.

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

(A) A plan or program operated by a national government or one (1) of its agencies; or

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

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

(40) Military service connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

(41) Never events—twenty-eight (28) occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

(42) Nocturnal enuresis alarm.

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

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

(45) Orthognathic surgery.

(46) Orthoptics.

(47) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

(48) Outpatient birthing centers.

(49) Over-the-counter medications—except for insulin and drugs recommended by the U.S. Preventive Services Task Force (Categories A and B) as prescribed by a physician and included on the formulary through the pharmacy benefit.

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

(51) Physical fitness.

(52) Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

(53) Private duty nursing.

(54) Prognathic and maxillofacial surgery.

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

(56) Self-inflicted injuries—not covered unless related to a mental diagnosis.

(57) Services not specifically included as benefits.

(58) Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

(59) Stimulators (for bone growth)—not covered unless prior authorized by claims administrator and clinical eligibility is met.

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

(61) Temporo-Mandibular Joint Syndrome (TMJ).

(62) Tobacco cessation—patches and gum are not covered.

(63) Transplant benefits at a non-network facility. Non-network facility charges and payments for transplants are limited to the following maximum only:

(A) Allogenic Bone Marrow—$143,000;
(B) Autologous Bone Marrow—$121,000;
(C) Heart—$128,000;
(D) Heart and Lung—$133,000;
(E) Lung—$151,000;
(F) Kidney—$54,000;
(G) Kidney and Pancreas—$97,000; and
(H) Liver—$153,000.

(64) Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar ($10,000) maximum per transplant when accessing network services. Travel expenses include travel and lodging allowance for recipient and his/her immediate family travel companion. When a participant is younger than nineteen (19) years of age, travel expenses are covered for both parents. Transplant facility must be more than one hundred (100) miles from the recipient's residence. Meals are not covered.

(65) Travel expenses—not covered except for transplants in a network facility.

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

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

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

(69) Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30,*

2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.070 Coordination of Benefits

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

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

(A) This coordination of benefits (COB) provision applies to MCHCP when a member has health care coverage under more than one (1) plan.

(B) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of MCHCP are determined before or after those of another plan. The benefits of MCHCP—

1. Shall not be reduced when, under the order of benefit determination rules, MCHCP determines its benefits before another plan; but

2. May be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

(2) Definitions. The following words and terms, when used in this rule, shall have the following meanings unless the context clearly indicates otherwise:

(A) Allowable expenses.

1. Allowable expense means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

2. Notwithstanding this definition, items of expense under coverages, such as dental care, vision care, prescription drug, or hearing-aid programs, may be excluded from the definition of allowable expense. A plan which provides benefits only for any of these items of expense may limit its definition of allowable expenses to like items of expense.

3. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

4. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

5. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of allowable expense must include the corresponding expenses or services to which COB applies.

6. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of this reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

A. Only benefit reductions based upon provisions similar in purpose to those described previously and which are contained in the primary plan may be excluded from allowable expenses.

B. This provision shall not be used to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services;

(B) Claim. A request for benefits of a plan to be provided or paid is a claim. The benefit claimed may be in the form of—

1. Services (including supplies);

2. Payment for all or a portion of the expenses incurred;

3. A combination of paragraphs (2)(B)1. and 2.; or

4. An indemnification;

(C) Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or similar provision takes effect;

(D) Coordination of benefits. This is a provision establishing an order in which plans pay their claims;

(E) Plan includes:

1. Group insurance and group subscriber contracts;

2. Uninsured arrangements of group or group-type coverage;

3. Group or group-type coverage through HMOs and other prepayment, group practice, and individual practice plans;

4. Group-type contracts. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of plan, at the option of the insurer or the service provider and the contract client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designed (for example, franchise or blanket). Individually underwritten and issued guaranteed renewable policies would not be considered group-type even though purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer. Note: The purpose and intent of this provision are to identify certain plans of coverage which may utilize other than a group contract but are administered on a basis more characteristic of group insurance. These group-type contracts are distinguished by two (2) factors—1) they are not available to the general public, but may be obtained only through membership in, or connection with, the particular organization or group through which they are marketed (for example, through an employer payroll withholding system) and 2) they can be obtained only through that affiliation (for example, the contracts might provide that they cannot be renewed if the insured leaves the particular employer or organization, in which case they would meet the group-type definition). On the other hand, if these contracts are guaranteed renewable allowing the insured the right to renewal regardless of continued employment or affiliation with the organization, they would not be considered group-type;

5. Group or group-type hospital indemnity benefits which exceed one hundred dollars ($100) per day;

6. The medical benefits coverage in group, group-type, and individual automobile no-fault type contracts but, as to traditional automobile fault contracts, only the medical benefits written on a group or group-type basis may be included; and

7. Medicare or other governmental benefits. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program;

(F) Plan shall not include:

1. Individual or family insurance contracts;

2. Individual or family subscriber contracts;

3. Individual or family coverage under other prepayment, group practice, and individual practice plans;

4. Group or group-type hospital indemnity benefits of one hundred dollars ($100) per day or less;

5. School accident-type coverages. These contracts cover grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24)-hour basis or on a to-and-from-school basis; and

6. A state plan under Medicaid and shall not include a law or plan when its benefits are in excess of those of any private insurance plan or other nongovernmental plan; and

(G) Primary plan/secondary plan. The order of benefit determination rules state whether MCHCP is a primary plan or secondary plan as to another plan covering this person. When MCHCP is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When MCHCP is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two (2) plans covering the person, MCHCP may be a primary plan as to one (1) or more other plans and may be a secondary plan as to a different plan(s).

(3) Order of Benefit Determination Rules.

(A) General. When there is a basis for a claim under MCHCP and another plan, MCHCP is a secondary plan which has its benefits determined after those of the other plan, unless—

1. The other plan has rules coordinating its benefits with those of MCHCP; and

2. Both those rules and MCHCP rules require MCHCP benefits be determined before those of the other plan.

(B) Rules. MCHCP determines its order of benefits using the first of the following rules which applies:

1. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that—if the person is also a Medicare beneficiary, and as a result of the rule established by the Title XVIII of the Social Security Act and implementing regulations, Medicare is—

A. Secondary to the plan covering the person as a dependent;

B. Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent;

C. Primary if the person is eligible for Medicare due to disability; and

D. Primary after the first thirty (30) months if the person is eligible for Medicare due to end stage renal disease;

2. Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different persons, called parents—

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;

3. Dependent child/separated or divorced. If two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order—

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child;

C. Then, the plan of the parent not having custody of the child; and

D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

4. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)2.;

5. Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits with itself; and

6. Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

(4) Effect on the Benefits of MCHCP. This section applies, which in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans. In that event, the benefits of MCHCP may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

(5) Right to Receive and Release Needed Information. Certain facts are needed to apply these COB provisions. MCHCP or its claims administrator has the right to decide which facts it needs. MCHCP or its claims administrator may get needed facts from or give them to any other organization or person. MCHCP or its claims administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under MCHCP must give MCHCP or its claims administrator any facts it needs to pay the claim.

(6) A payment made under another plan may include an amount which should have been paid under MCHCP. If it does, MCHCP or its claims administrator may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under MCHCP. MCHCP or its claims administrator will not have to pay that amount again. The term, payment made includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

(7) If the amount of the payments made by MCHCP or its claims administrator is more than it should have paid under this COB provision, MCHCP or its claims administrator may recover the excess from one (1) or more of—

(A) The person it has paid or for whom it has paid;

(B) Insurance companies; or

(C) Other organizations. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

(8) MCHCP shall, with respect to COB and recoupment of costs, exercise all rights and remedies as permitted by law.

AUTHORITY: sections 103.059 and 103.089, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Rescinded and readopted: Filed July 1, 2010, effective Dec. 30, 2010.*

**Original authority: 103.059, RSMo 1992 and 103.089, RSMo 1992.*

22 CSR 10-3.075 Review and Appeals Procedure

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

(1) Claims Submissions and Initial Benefit Determinations.

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

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

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

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

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

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

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

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

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

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

1. The reasons for the denial;

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

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

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

(2) General Appeal Provisions.

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

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

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

(3) Appeal Process for Medical and Pharmacy Determinations.

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

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

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

B. A denial, reduction, or termination

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

C. Any rescission of coverage once an individual has been covered under the plan.

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

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

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical and pharmacy benefits administered by plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc., in accordance with state law and regulations promulgated by DIFP and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010.

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

6. Final external review decision. A final external review decision means a determination rendered under the DIFP external review process at the conclusion of an external review.

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

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

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

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

(B) Internal Appeals.

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

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

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

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

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review by DIFP.

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

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

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

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

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

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

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

(V) For members with medical coverage through UMR—

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

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

(b) Second level appeals must be

sent in writing to—

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

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

(VI) For members with medical coverage through Mercy Health Plans—

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

Mercy Health Plans
Attn: Corporate Appeals
14528 S. Outer 40 Road, Suite 300
Chesterfield, MO 63017

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

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

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

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

Express Scripts
Clinical Appeals—MH3
6625 West 78th Street, BL0390
Bloomington, MN 55439
or by fax to 1-877-852-4070

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

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

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

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

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

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

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

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, the MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year.

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

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

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January.

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

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage.

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

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

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

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

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Amended: Filed Dec. 22, 2008, effective June 30, 2009. Amended: Filed Feb. 17, 2010, effective Aug. 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, terminated Jan. 20, 2011. Emergency amendment filed Jan. 10, 2011, effective Jan. 20, 2011, expired June 29, 2011. Amended: Filed Jan. 10, 2011, effective June 30, 2011.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.080 Miscellaneous Provisions

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

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

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

(3) Confidentiality of Records. The health records of the participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to the officers and employees of the plan or claims administrator or his/her legal representatives who have a need for the records in the performance of their duties; or unless disclosure would be for a routine use by the plan or claims administrator for a purpose which is compatible with the purpose for which it was collected; or unless disclosure of the records would be to the commissioner of administration, or his/her legal representative, for the sole purpose of preventing fraudulent or redundant medical claims to either the Missouri Consolidated Health Care Plan, Missouri, or other public entities as an employer or self-insurer of Workers' Compensation for use in the investigation of a Workers' Compensation claim; or unless disclosure of the records is to the participant to whom the record pertains; or unless disclosure of the record is pursuant to the order of a court of competent jurisdiction. The parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity by a court of competent jurisdiction, may act on behalf of the individual.

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

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.

(1) The pharmacy benefit provides coverage for prescription drugs listed on the formulary, as described in the following:

(A) Medications.

1. Retail—Network:

A. Generic: Eight-dollar ($8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. Brand: Thirty-five-dollar ($35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

C. Mail order program—

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for a twenty-dollar ($20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent ($87.50) copayment for a brand drug on the formulary.

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments—

(a) Generic: eight dollars ($8) for generic drug on the formulary list; and

(b) Brand: thirty-five dollars ($35) for brand drug on the formulary.

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment or coinsurance. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.

(3) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step—

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;

2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.

(4) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.

(5) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—

(A) Complete the claim form; and

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include:

1. Pharmacy name and address;

2. Patient's name;

3. Price;

4. Date filled;

5. Drug name, strength, and national drug code (NDC);

6. Prescription number;

7. Quantity; and

8. Days' supply.

(6) Formulary—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or

(C) A drug is determined to have a safety issue.

(7) Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug. Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

(D) Biologics for inflammatory conditions;

(E) Cancer drugs;

(F) Hemophilia drugs (Factor VIII and IX concentrates);

(G) Hepatitis drugs;

(H) Immunosuppressants (transplant anti-rejection agents);

(I) Insulin (basal);

(J) Low molecular weight heparins;

(K) Multiple sclerosis injectable drugs;

(L) Novel psychotropics (oral products and long-active injectables);

(M) Phosphate binders;

(N) Pulmonary hypertention drugs; and

(O) Somatostatin analogs.

(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.092 Dental Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Dental Benefit Summary for members of the Missouri Consolidated Health Care Plan.

(1) Two (2) dental benefit packages are available for a public entity to choose from—basic and high.

(A) The basic benefit package provides coverage for—

1. Coverage A—diagnostic and preventive services;

2. Coverage B—basic and restorative services; and

3. Coverage C—major services.

(B) The high benefit package provides coverage for—

1. Coverage A—diagnostic and preventive services;

2. Coverage B—basic and restorative services;

3. Coverage C—major services; and

4. Coverage D—orthodontic services for children younger than nineteen (19).

(2) Procedures for Using the Dental Plan. A member may visit the dentist of his/her choice and select any dentist on a treatment-by-treatment basis. Members may go to a participating or non-participating network dentist. If a member goes to a non-participating network dentist, the dental plan will make payment directly to the member on the lesser of the dentist billed charge or the applicable maximum plan allowance.

(3) Dental benefits, deductibles, and coinsurance include:

DENTAL SERVICES			
	BASIC	**HIGH**	
Coverage A – Diagnostic & Preventive	**You Pay**	**You Pay**	**Note**
Examinations Prophylaxis (teeth cleaning) Fluoride X-rays Emergency Palliative Treatment Space Maintainers Sealants	No deductible 0% coinsurance	No deductible 0% coinsurance	Dental exams, X-rays, cleanings and fluoride treatment do not apply to the individual plan maximum
Coverage B – Basic & Restorative	**You Pay**	**You Pay**	**Note**
Minor Restorative Services (fillings) Oral surgery, including extractions Periodontics Endodontics	$50/person deductible* 20% coinsurance	$50/person deductible* 20% coinsurance	
Coverage C – Major Services	**You Pay**	**You Pay**	**Note**
Prosthodontics (bridges, dentures) Major Restorative Services (crowns, inlays, onlays, labial veneers)	$50/person deductible* 50% coinsurance	$50/person deductible* 50% coinsurance	12-month waiting period applies to replacement prosthetic devices. The waiting period is waived with proof of 12-month continuous dental coverage for major services immediately prior to the effective date of coverage in MCHCP's dental plan
Coverage D – Orthodontic Services for children younger than 19	**You Pay**	**You Pay**	**Note**
Treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position	Orthodontia is not covered	$50/child deductible* 50% coinsurance	Orthodontic lifetime maximum of $1,000 per dependent child younger than 19
Coverage is limited to $1,000 per person per calendar year benefit period. **Coinsurance amounts apply after the $50 individual deductible is met under Coverage B, C or D, or combined.*			

(4) Alternative Treatment. If alternative treatment plans are available, this dental plan will be liable for the least costly, professionally satisfactory course of treatment. This includes, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of the amalgam (silver) filling. This also includes fixed bridges, in which case the benefits will be based on the allowed amount of a removable partial denture.

(5) Transferring Care. If participant receives care from more than one (1) dentist or service provider for the same procedure, benefits will not exceed what would have been paid for one (1) dentist for that procedure (including, but not limited to, prosthetic devices and root canal therapy).

(6) Claim Pre-Determination. If the care member needs costs less than two hundred dollars ($200) or is emergency care, member's dentist will proceed with treatment at member's option. If the cost estimate is more than two hundred dollars ($200) and is not emergency care, member's dentist will determine what treatment member needs and could submit a treatment plan to dental plan for a pre-determination of benefits. This estimate will enable the member to determine in advance how much of the cost will be paid by his/her dental coverage and how much he/she will be responsible for paying.

(7) Claim Filing Deadline. Member's claims must be filed by the end of the calendar year after the year in which services were rendered. The dental plan is not obligated to pay claims submitted after this period. If a claim is denied due to a participating dentist's failure to make timely submission, participant will not be liable to such dentist for the amount that would have been payable by the dental plan, provided that member advised the dentist of participant's eligibility for benefits at the time of treatment.

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.093 Vision Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the vision benefit summary for members of the Missouri Consolidated Health Care Plan.

(1) Vision Plan. The vision benefit provides coverage of refractive care exams, eyeglass lenses and frames, contact lenses, and corrective laser surgeries.

(2) Vision benefits and copayments include:

VISION SERVICES		
BENEFITS	**NETWORK**	**NON-NETWORK**
Exams – once every 12 months		
Vision Exam	$10 copayment	Reimbursed up to $36
Lenses – once every 12 months – one $25 copayment for lenses and frames when purchased together		
Single vision lenses (per pair)	$25 copayment	Reimbursed up to $28
Bifocal lenses (per pair)	$25 copayment	Reimbursed up to $45
Trifocal lenses (per pair)	$25 copayment	Reimbursed up to $56
Lenticular lenses (per pair)	$25 copayment	Reimbursed up to $80
Polycarbonate lenses (per pair) Applies to dependent children only	$25 copayment	Not covered
Frames – once every 24 months – one $25 copayment for lenses and frames when purchased together		
Frames	**$25 copayment** **Up to $120 plus 20% discount on any out-of-pocket costs**	**Reimbursed up to $45**
Contact Lenses – once every 12 months in place of eye glass lenses		
Elective If member prefers contacts to glasses	$10 copayment for exam Up to $125 for contact lenses and contact lens exam (fitting and evaluation) 15% discount on the cost of contact lens exam (fitting and evaluation)	Reimbursed up to $36 for exam Contact lenses, evaluation, design and fitting reimbursed up to $105
Necessary If medically necessary with prior approval from VSP	$10 copayment for exam Additional costs covered at 100%	Reimbursed up to $36 for exam Contact lenses, evaluation, design and fitting reimbursed up to $210
Corrective Laser Surgery – contact your provider, or contact VSP at 888-354-4434 for more information		

PRK	Maximum amount you pay: $1,500 per eye	Not covered
LASIK	Maximum amount you pay: $1,800 per eye	Not covered
Custom LASIK	Maximum amount you pay: $2,300 per eye	Not covered
Other		
Optional Items (cosmetic extras)	Not covered	Not covered

(3) Value-Added Discount Program. A member can receive a twenty-percent (20%) discount on additional glasses and sunglasses, including lens options from any network provider, within twelve (12) months of participant's last eye exam.

(4) Soft Contact Lenses. A member who wears soft contact lenses will qualify for a special contact lens program. The program covers—

(A) A contact lens exam;

(B) Six (6)-month supply of contacts from the specific list of contact lens products and manufacturers; and

(C) Two (2) follow-up visits.

(D) A member who requires premium services when being fitted for contact lenses will not qualify for the contact lens care program. The member's provider will determine if the member qualifies for a standard fit or a premium fit based on the guidelines of—

1. Standard fit contact lens patients—

A. Typically the member does not require additional time for care, training, or problem solving; and

B. Typically the member can be successfully fitted in up to two (2) follow-up visits; and

2. Premium fit contact lens patients—

A. Typically the member will require additional time for care, training, or problem solving; and

B. Typically the member cannot be successfully fitted in up to two (2) follow-up visits.

(E) The member will be responsible for the cost above the allowed network or non-network contact lens benefit. Contact lens care program products, manufacturers, replacement fees, and refit fees are as follows:

Tier One: Spherical				
Product	**Manufacturer**	**Boxes Covered**	**Replacement Wearers**	**Refit Wearers**
ACUVUE	Vistakon	4	$130	$170
ACUVUE 2	Vistakon	4		
AIR OPTIX AQUA	CIBA Vision	2		
Biofinity	CooperVision	2		
Biomedics 55 Premier	CooperVision	4		
Biomedics 55 UV	CooperVision	4		
Biomedics XC	CooperVision	4		
Focus Monthly Visitint (Focus Visitint)	CIBA Vision	2		
Frequency 38	CooperVision	2		
Frequency 55 Aspheric	CooperVision	2		
Frequency 55 Sphere	CooperVision	2		
FreshLook Handling Tint	CIBA Vision	4		
O2OPTIX	CIBA Vision	2		
Proclear Sphere (Compatibles)	CooperVision	2		
PureVision	Bausch & Lomb	2		
SofLens 39 (Optima FW, Seequence II)	Bausch & Lomb	4		
Vertex Sphere (Encore Sphere)	CooperVision	4		

Tier Two: Spherical				
Product	**Manufacturer**	**Initial Supply Boxes**	**Replacement Wearers**	**Refit Wearers**
ACUVUE ADVANCE	Vistakon	4	$160	$190
ACUVUE OASYS with HYDRACLEAR PLUS	Vistakon	4		
AIR OPTIX NIGHT & DAY AQUA	CIBA Vision	2		
Avaira	CooperVision	4		
Biomedics 38	CooperVision	4		
Extreme H_20 59% - Thin	Hydrogel	4		
Extreme H_20 59% - Xtra	Hydrogel	4		
Extreme H_20 54%	Hydrogel	4		
Focus 1-2 Week Visitint (NewVues Visitint)	CIBA Vision	4		
PRECISION UV	CIBA Vision	4		

Tier Three: Specialty Lenses				
Product	**Manufacturer**	**Initial Supply Boxes**	**Replacement Wearers**	**Refit Wearers**
ACUVUE ADVANCE *for ASTIGMATISM*	**Vistakon**	**4**	**$180**	**$210**
ACUVUE OASYS *for ASTIGMATISM*	**Vistakon**	**4**		
AIR OPTIX *for ASTIGMATISM*	**CIBA Vision**	**2**		
Biofinity Toric	**CooperVision**	**2**		
Focus Monthly Toric Visitint (Focus Toric)	**CIBA Vision**	**2**		
Frequency 55 Multifocal	**CooperVision**	**2**		
Frequency 55 Toric	**CooperVision**	**2**		
Proclear EP Multifocal	**CooperVision**	**4**		
PureVision Multifocal	**Bausch & Lomb**	**2**		
PureVision Toric	**Bausch & Lomb**	**2**		
SofLens Toric	**Bausch & Lomb**	**4**		

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**Original authority: 103.059, RSMo 1992.*