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

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

22 CSR 10-2.010 Definitions

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

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

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

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

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

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

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

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions (22 CSR 10-2.040), (22 CSR 10-2.045), (22 CSR 10-2.050), (22 CSR 10-2.055), (22 CSR 10-2.060), (22 CSR 10-2.063), (22 CSR 10-2.064), (22 CSR 10-2.065), and (22 CSR 10-2.066) as interpreted by the plan administrator;

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

(H) Claims administrator—An organization or group responsible for the processing

of claims and associated services for the preferred provider organization (PPO) and co-pay plans;

(I) Co-pay plan—A set of benefits similar to the premium option. Co-payment amounts are generally an average of those for the premium and standard options;

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

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

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

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

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

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

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

2. Employees transferred from a department or other public entity with coverage under another medical care plan into a department or other public entity covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation subject to the provisions of 22 CSR 10-2.060(1)(Q)1.

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

4. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a

new state employee in the subsequent month, and their eligible dependents who were covered by the PPO plan, will be eligible for participation retroactive to the date following termination of participation;

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

1. Employed on a full-time basis;

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

3. Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning;

4. Married; or

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

(Q) Employee and dependent participation—Participation of an employee and the employee's eligible dependents. Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren). Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-2.020(1)(A)9.;

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

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

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

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

(V) Home health agency—An agency certified by the Missouri Department of Health, or any other state's licensing or certifying body, to provide health care services to persons in their homes;

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

(X) Hospital.

1. An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided

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

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

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

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

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

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

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

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

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

(CC) 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;

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

(EE) 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;

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

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

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

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

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

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

(LL) Plan document—This statement of the terms and conditions of the plan as adopted by the plan administrator;

(MM) Plan year—Same as benefit year;

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

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

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

(QQ) Premium option—A set of covered benefits with specified co-payment and coinsurance amounts;

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

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

(TT) 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;

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

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

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

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

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

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(VV) of this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97);

(XX) Staff model—A set of covered benefits established by the HMO similar to the premium and standard options, but with varying co-payment and coinsurance amounts;

(YY) Standard option—A set of covered benefits similar to the premium option, but with higher co-payment and coinsurance amounts;

(ZZ) State—Missouri;

(AAA) Unemancipated child(ren)—A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

1. Stepchild(ren);
2. Foster child(ren) for whom the employee is responsible for health care;
3. Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;
4. Other child(ren) for whom the

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

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

(BBB) Usual, customary, and reasonable charge.

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

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

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

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June*

30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.020 Membership Agreement and Participation Period

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

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

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

1. For groups of less than five hundred (500) employees, the MCHCP will be the only health care offering made to its eligible members. For groups of five hundred (500) or more employees the entity may maintain a self-insured preferred provider organization (PPO) plan or one point-of-service (POS) option (either self-insured or on a fully-insured directly contracted basis), but may not offer a competing plan of the same type through the MCHCP (also see paragraph (1)(A)8.);

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

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

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

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

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

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

8. Public entities joining the plan must offer their eligible members all the plans available through the MCHCP;

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

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

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

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

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

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

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

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

(A) Employee Participation.

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

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

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

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

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

the employee's participation becomes effective;

2. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made; and

3. Unless required under federal guidelines—

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

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (4)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan.)

(C) Effective Date Proviso.

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

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

long-term disability recipients covered under the plan.)

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

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

(A) Written request by the employee;

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

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

(D) 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 (6) and (7).

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

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

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

(7) Continuation of Coverage.

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

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

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

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

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

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

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

1. Eligibility Criteria:

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

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

C. Coverage since first eligible;

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

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one 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, long-term disability recipients and their dependents are not later eligible if they discontinue their coverage at some future time.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement

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

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment directly from the leave, but they will be subject to pre-existing limitations, when applicable. Preexisting limitations under this provision will not apply to HMO or POS members. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (5)(C). Coverage may be reinstated upon return from military leave without proof of insurability or preexisting conditions. However, the former member must complete an enrollment form.

(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 employ-

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

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. No pre-existing condition limitation will apply. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. If the employee participates in a PPO plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.

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

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

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

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

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

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

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

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

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

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

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

*AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14,*

1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed March 17, 1997, effective July 1, 1997, expired Sept. 22, 1997. Amended: Filed March 17, 1997, effective Aug. 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 18, 1998, effective Jan. 1, 1999, expired June 29, 1999. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.030 Contributions

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

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

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

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

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

April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.040 PPO Plan Summary of Medical Benefits

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

(1) Lifetime maximum, three (3) million dollars.

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

(3) Deductible Amount—Per individual for the preferred provider organization (PPO) plan each calendar year, three hundred dollars (\$300), family limit each calendar year, nine hundred dollars (\$900).

(4) Coinsurance.

(A) Individual:

1. PPO—Ninety percent (90%) of the first seven thousand five hundred dollars (\$7,500) of covered charges in the calendar year which are subject to coinsurance, one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPOs.

2. Non-network—Seventy percent (70%) of the first seven thousand five hundred dollars (\$7,500) of covered charges in the calendar year which are subject to coinsurance, one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPOs.

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

(B) Family:

1. PPO—Ninety percent (90%) of the first fifteen thousand dollars (\$15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges

in the calendar year, but see the provision applicable to PPO.

2. Non-network—Seventy percent (70%) of the first fifteen thousand dollars (\$15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to PPO.

3. Out-of-area—Eighty percent (80%) of the first fifteen thousand dollars (\$15,000) of covered charges in the calendar year which are subject to coinsurance; one hundred percent (100%) of any excess of covered charges in the calendar year, but see the provision applicable to PPO.

(5) The deductible will be waived and the employee or dependent will only be responsible for a ten dollar (\$10) co-payment for an office visit for covered services if a physician or provider is utilized who is enrolled in a preferred provider network that has contracted with the plan administrator. Charges for other covered services provided in addition to the office visit will be covered under the regular PPO benefit(s) available at the time of service.

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

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

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

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

(C) Large Case Management—Members that require long-term acute care may be offered the option of receiving the care, if

appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

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

(E) Penalties—Members not complying with subsections (7)(A) and (B) may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

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

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

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

(9) Prescription Drug Program—The PPO plan provides coverage for prescription drugs as described in the following:

(A) Medications.

1. In-Network.

A. Ten dollar (\$10) co-pay for thirty (30)-day supply for generic drug on the formulary.

B. Twenty dollar (\$20) co-pay for thirty (30)-day supply for brand drug on the formulary.

C. Thirty-five dollar (\$35) co-pay for thirty (30)-day supply for non-formulary drug.

2. Prescriptions filled with a brand drug when a generic is available will be subject to the generic co-payment amount and the member must also pay the difference in the cost between the generic and brand drugs.

3. Mail Order Program—Prescriptions may be filled through mail order program for up to a ninety (90)-day supply for twice the regular co-payment.

(B) 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, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable co-payment. Any difference between the amount paid by the member at a non-network pharmacy and the amount that would have been allowed at an in-network pharmacy will not be applied to the out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 2000.
Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and re-adopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, terminated Jan. 14, 2000. Emergency amendment filed Jan. 4, 2000, effective Jan. 14, 2000, terminated Feb. 18, 2000. Emergency amendment filed Feb. 8, 2000, effective Feb. 18, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and re-adopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002.*

**Original authority: 103.059, RSMo 1992.*



22 CSR 10-2.045 Co-Pay Plan Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical benefits for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

- (1) Lifetime Maximum:
 - (A) Network—no limit.
 - (B) Out-of-network, out-of-area—three (3) million dollars.
- (2) Automatic Annual Reinstatement—Maximum, five thousand dollars (\$5,000).
- (3) Non-Network and Out-of-Area Deductible Amount—
 - (A) Network—zero.
 - (B) Out-of-Network, Out-of-Area—three hundred dollars (\$300) individual, nine hundred dollars (\$900) family, per calendar year.
- (4) Coinsurance.
 - (A) Individual—
 - 1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the two thousand dollar (\$2,000) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.
 - 2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the four thousand five hundred dollar (\$4,500) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.
 - 3. Out-of-area—Eighty percent (80%) coinsurance applies to covered services after satisfying one thousand five hundred dollar (\$1,500) individual out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.
 - (B) Family—
 - 1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the six thousand dollar (\$6,000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.
 - 2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the nine thousand dollar (\$9,000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

3. Out-of-area—Eighty percent (80%) coinsurance applies to covered services after satisfying three thousand dollar (\$3,000) family out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.

(C) Non-Network Services—Same as subsections (4)(A) and (B) of this rule, except covered charges are reimbursed on a seventy percent (70%) basis.

(5) The employee or dependent will only be responsible for a fifteen dollar (\$15) co-payment for an office visit for covered services if a physician or provider is utilized who is enrolled in a preferred provider network that has contracted with the plan administrator.

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

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

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

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

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

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided

and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (7)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

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

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

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

(9) Prescription Drug Program—The co-pay plan provides coverage for prescription drugs as described in the following:

(A) Medications.

1. In-Network.

A. Ten dollar (\$10) co-pay for thirty (30)-day supply for generic drug on the formulary.

B. Twenty dollar (\$20) co-pay for thirty (30)-day supply for brand drug on the formulary.

C. Thirty-five dollar (\$35) co-pay for thirty (30)-day supply for non-formulary drug.

2. Prescriptions filled with a brand drug when a generic is available will be subject to the generic co-payment amount and the member must also pay the difference in the cost between the generic and brand drugs.

3. Mail Order Program—Prescriptions may be filled through a mail order program

for up to a ninety (90)-day supply for twice the regular co-payment.

(B) 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, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable co-payment. Any difference between the amount paid by the member at a non-network pharmacy and the amount that would have been allowed at an in-network pharmacy will not be applied to the out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2002, effective June 30, 2002.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.050 PPO Plan Benefit Provisions and Covered Charges

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

(1) Benefit Provisions.

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

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

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

(D) The total amount of benefits payable for all covered charges incurred during an individual's lifetime shall not exceed the lifetime maximum specified in the summary of

benefits, subject to reinstatement as provided in subsections (1)(E) and (F) of this rule.

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

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

(2) Covered Charges.

(A) Only charges for those services listed in this rule which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service, and which are—*a*) prescribed by a doctor or provider for the therapeutic treatment of injury or sickness; *b*) to the extent they don't exceed any limitation; *c*) not excluded by the limitations; and *d*) for not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

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

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

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

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

3. Type C charges for preadmission testing (X-ray and laboratory tests) which are conducted and which are necessary for hospital admission and which are not duplicated

for screening purposes upon admission to the hospital.

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

A. Those included in paragraphs (2)(C)1.-3. of this rule; and

B. Special nursing care.

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

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

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

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

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

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

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

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

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

B. Casts, splints or crutches;

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

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

(II) A disabling condition existing since birth;

D. Oxygen and rental of equipment for giving oxygen; rental of wheelchair or scooter (manual or powered) or hospital equipment to aid in breathing;

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

F. Colostomy bags and ureterostomy bags;

G. Bilateral hearing aids; and

H. Augmentative communication devices.

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

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

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

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

B. Follows surgery to correct a birth defect.

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

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

18. Type R charges for outpatient treatment chemical dependency.

19. Type S charges for hospice services.

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

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

22. Type V charges for transplants.

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

24. Type X charges for normally covered services arising from a non-covered service.

25. Type Y charges for Internet Physician Visits when enrolled in the Care Support Program and registered for the service.

(D) If covered charges provide for rental of durable equipment and the participant's condition is such that use of the equipment is projected for a period of time to make purchase of the equipment less costly than rental, then with the advanced authorization by the claims administrator or his/her designee, the equipment may be purchased and the purchase price will be considered a covered charge. At the option of the claims administrator, or his/her designee, durable equipment may be purchased based on quali-

ty and cost considerations. Maintenance and repair of purchased equipment is covered if provider supplies statement of continued medical necessity in time intervals determined by claims administrator or his/her designee.

*AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.055 Co-Pay Plan Benefit Provisions and Covered Charges

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

(1) Covered Charges.

(A) Allergy Injections—Fifteen dollar (\$15) co-payment for office visit also covers injection. Ten dollar (\$10) co-payment per injection received if not during office visit.

(B) Ambulance Service—Ground services covered with fifty dollar (\$50) co-payment if medically necessary or with prior approval. Air services covered on same basis, twenty percent (20%) coinsurance and deductible for non-emergencies.

(C) Birth Control Pills—Birth control pills on the formulary covered at one hundred percent (100%). Not covered out-of-network.

(D) Chiropractic Benefits—Charges subject to fifteen dollar (\$15) co-payment; fifty

dollar (\$50) co-pay per visit maximum, two thousand dollar (\$2,000) annual maximum (out-of-network only).

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

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restorative services that are a result of that injury. Fifteen dollar (\$15) office visit co-pay, regardless of where services are rendered.

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

(H) Emergency Care—Fifty dollar (\$50) co-payment in or out of service area. Waived if admitted.

(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a fifteen dollar (\$15) co-payment.

(J) Growth Hormone Therapy—Subject to twenty percent (20%) coinsurance, medical necessity and prior authorization.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to twenty percent (20%) co-payment and fifteen dollar (\$15) co-payment for annual hearing test.

(L) Home Health Care—Covered when authorized by claims administrator.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefit for Mental and Nervous Disorder—One hundred dollar (\$100) co-payment per admission. Four hundred dollar (\$400) annual inpatient hospital maximum. Must be pre-certified.

(O) Hospital Benefits for Chemical Dependency—One hundred dollar (\$100) co-payment per admission. Four hundred dollar (\$400) annual inpatient hospital maximum. Must be precertified.

(P) Hospital Room and Board—One hundred dollar (\$100) co-payment per admission. Four hundred dollar (\$400) annual maximum. Must be precertified.

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

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

(S) Maternity Coverage—Fifteen dollar (\$15) co-payment for initial visit. All other

prenatal visits, delivery costs and routine post-natal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

(T) Nutrient Supplement—Not covered out-of-network.

(U) Organ Transplants—The following organ transplants covered at one hundred percent (100%) through the National Transplant Program: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by the claims administrator. Donor expenses are covered. No waiting periods allowed. Non-network and out-of-area limited to maximum surgical schedule.

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

(W) Outpatient Mental and Nervous Disorder and Chemical Dependency—Fifteen dollar (\$15) co-payment per visit.

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

(Y) Physical Therapy and Rehabilitation Services—Ten dollar (\$10) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits if medically necessary.

(Z) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after fifteen dollar (\$15) co-payment per office visit.

3. Internet—Covered when enrolled in the Care Support Program and registered for the service.

(AA) Plan Maximum—Not applicable for network services, out-of-network and out-of-area limited to three (3) million dollars with five thousand dollars (\$5,000) reinstatement.

(BB) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

1. Ten dollar (\$10) co-pay for thirty (30)-day supply for generic drug on the formulary.

2. Twenty dollar (\$20) co-pay for thirty (30)-day supply for brand drug on the formulary.

3. Thirty-five dollar (\$35) co-pay for thirty (30)-day supply for non-formulary drug.

4. Ninety (90)-day supply of medication for two (2) co-payments (mail order only).

(CC) Preventive Services—Annual physical exams, mammograms (subject to sched-

ule), pap smears, well-baby care, immunizations. Annual well-woman exam without referral to a network provider.

(DD) Prosthetics—Provided in full for initial placement. Twenty percent (20%) coinsurance for coverage for repair or replacement due to change in medical condition.

(EE) Skilled Nursing—Provided in full. Limited to one hundred and twenty (120) days.

(FF) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Fifty dollar (\$50) co-payment.

*AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment Filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002.*

**Original authority: 103.059, RSMo 1992.*

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

PURPOSE: This rule establishes the policy of the board of trustees in regard to the limitations in the Missouri Consolidated Health Care Plan PPO Plan and Co-Pay Plan.

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

(A) If applicable, all hospitalizations, outpatient treatment for chemical dependency or mental and nervous disorder are not precertified as described in 22 CSR 10-2.040(7)(A), reimbursement will be reduced by ten percent (10%) of reasonable and customary charges;

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

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

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

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

3. Any other accidental injury or sickness but only for expenses incurred after this coverage has been in force for at least six (6) months; or

4. A birth defect; or

5. Mastectomies;

(D) Hearing aids once every two (2) years and the fitting, eye refractions and glasses, contact lenses or their fitting of eye glasses or contact lenses (other than the first pair of contact lenses or eye glasses or the fitting after cataract surgery which is performed while covered under these rules);

(E) Injury or sickness resulting from—

1. Act of war (declared or undeclared);

2. Insurrection; or

3. Atomic explosion or other release of nuclear energy under any condition except when used solely as medical treatment;

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

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

2. Any state's cash sickness or similar law including any group insurance policy approved under such law;

(G) Medical care and supplies for which—

1. No charge is made;

2. The member or dependent is not required to pay, including but not limited to, any portion of any charges that are discounted; and

3. Charges exceed the usual, customary and reasonable rate (does not apply to network services for preferred provider organization (PPO) or co-pay plan);

(H) Injury or sickness resulting from taking part in the commission of a felony;

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

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

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

1. Procedures used for diagnosis;

2. Procedures used for balance;

3. Restoration;

4. Fixed devices; and

5. Movable devices;

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

1. Extraction of bony and partial bony impactions (not covered by co-pay plan); and

2. Treatment or examination of injuries to sound and natural teeth sustained in an accident while covered under the rule, or such treatment received after the patient has been covered under the plan for at least

twelve (12) consecutive months; and provided the injury/illness was incurred within one (1) year of the effective date of coverage;

(M) Except as may otherwise be specifically provided, expenses for equipment, services or supplies for any of the following, regardless of whether or not prescribed by a physician or provider:

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

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

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

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

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

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

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

- B. Who is the spouse or another relative who lives with a physician whose income

is directly or indirectly affected by the fee paid for the performance of the abortion;

(Q) Preexisting conditions, except charges incurred after the individual has been a participant for six (6) consecutive months. A preexisting condition is one for which medical care was received or prescribed drugs were taken, or for which expenses were incurred during the three (3) months prior to the participant's effective date. This limitation does not apply to participants transferred from another plan as provided in 22 CSR 10-2.010(1)(O)2. or 22 CSR 10-2.020(1)(A)4.;

1. Exceptions to preexisting conditions.

- A. If the member had previous coverage and the break in coverage was less than sixty-three (63) days, the preexisting limitations will be reduced by the time covered under the previous plan; and

- B. Preexisting limitations do not apply to:

- (I) Members enrolled in a separate plan through Missouri Consolidated Health Care Plan (MCHCP) for the preceding six (6) months; or

- (II) Pregnancies, newborn children, or children placed for adoption;

- (R) Chemical dependency and mental and nervous disorder treatments in PPO plan are limited to:

1. Network provider.

- A. First five (5) visits paid with a ten dollar (\$10) co-payment;

- B. Visits six (6) through ten (10) with a fifteen dollar (\$15) co-payment;

- C. Additional visits paid with a twenty dollar (\$20) co-payment; and

- D. Outpatient hospital services subject to deductible and ten percent (10%) coinsurance;

2. Non-network provider—Subject to deductible and thirty percent (30%) coinsurance, out-of-area twenty percent (20%) coinsurance;

- (S) Outpatient chemical dependency and mental and nervous disorder treatments in the co-pay plan are limited to:

1. Network provider.

- A. Fifteen dollar (\$15) co-payment for office visits;

- B. Outpatient hospital services covered at one hundred percent (100%);

2. Non-network provider—subject to deductible and thirty percent (30%) coinsurance, out-of-area twenty percent (20%) coinsurance;

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

- (U) Chiropractic services are limited to a maximum allowable charge of fifty dollars (\$50) per visit, and a two thousand dollar (\$2,000) total annual maximum. Diagnostic

lab and X-ray services are not included in the fifty dollar (\$50) maximum per visit, but are included in the two thousand dollar (\$2,000) total annual maximum. In-network office visits in the co-pay plan are subject to a fifteen dollar (\$15) co-payment;

- (V) Associated charges for non-covered services;

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

- (X) Vitamins and nutrient supplements, except prescription prenatal vitamins, vitamin B₁₂ shots, and certain vitamin therapies as determined by the claims administrator;

- (Y) Treatment of temporal mandibular joint dysfunction (TMJ) not covered unless approved by claims administrator;

- (Z) Reversals of tubal ligations and vasectomies;

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

- (BB) Preferred Provider Organization (PPO) Office Visit Co-payments;

- (CC) Transplants are limited to heart, lung, liver, kidney, cornea, bone marrow, pancreas and intestinal, and are subject to medical necessity and effectiveness criteria and payment levels as determined by the claims administrator's guidelines;

Benefits are allowed in accordance with the following schedule:				
Benefit Description	The First Health National Transplant Program	First Health Network (PPO) Hospital	Non-PPO Hospital	Additional Limitations and Explanations
Plan Pays	100%	90% of NTP fees	70% of NTP fees	Travel, lodging and meals allowance is for the transplant recipient and his or her immediate family travel companion (under age 19, both parents). The plan's co-payment will be reduced by 10% when not using The First Health National Transplant Program if you do not follow the procedures required by the clinical management services program. This penalty and your non-PPO coinsurance do not apply to the out-of-pocket maximum.
Annual Deductible	NO	YES	YES	
Organ Donor Costs Per Transplant	Unlimited	\$10,000	\$10,000	
Travel, Lodging And Meals Allowance Per Transplant	\$10,000	None	None	
Lifetime Benefit Maximum	Subject to Plan Maximum	Subject to Plan Maximum	Subject to Plan Maximum	

1. Cornea transplant covered under surgical benefit.

(DD) In addition to any other listed limitations, out-of-network services in the PPO and co-pay plans are subject to the deductible and seventy/thirty percent (70/30%) coinsurance out-of-network, eighty/twenty percent (80/20%);

(EE) Skilled nursing charges limited to one hundred twenty (120) days per calendar year;

(FF) *In vivo* artificial insemination subject to deductible (not applicable in co-pay plan) and fifty percent (50%) coinsurance, which does not apply to the out-of-pocket maximum. Not covered out-of-network;

(GG) Eye refractions limited to one annually and only if provided in the network;

(HH) Treatment of nearsightedness, farsightedness and astigmatism; and

(II) Physician Internet Visits are limited to twenty-four (24) visits per year and a \$600 annual maximum.

AUTHORITY: section 103.059, RSMo 2000.*
Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amend-

ment filed Nov. 25, 1997, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001.

*Original authority: 103.059, RSMo 1992.

22 CSR 10-2.063 HMO/POS Premium Option Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the summary of medical benefits in the Missouri Consolidated Health Care Plan HMO and POS Premium Plans.

(1) Covered Charges.

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

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

(C) Birth Control Pills—Birth control pills on formulary covered at one hundred percent (100%). Oral contraceptives are not subject to coinsurance or co-payments.

(D) Chiropractic Benefits.

1. Health maintenance organization (HMO) and point-of-service (POS) in-network—Charges subject to ten dollar (\$10) co-payment.

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

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

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restorative services as a result of that injury.

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

(H) Emergency Care—Fifty dollar (\$50) co-payment in or out of service area. Waived if admitted.

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

(J) Growth Hormone Therapy—Subject to twenty percent (20%) coinsurance. Subject to medical necessity and authorization by HMO or POS.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to twenty percent (20%) co-payment and ten dollar (\$10) co-payment for annual hearing test. POS out-of-network not covered.

(L) Home Health Care—Covered when authorized by HMO or POS physician. POS non-network limited to sixty (60) annual visits.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefits for Mental and Nervous Disorder—Provided in full with proper authorization.

(O) Hospital Benefits for Chemical Dependency—Same as for mental and nervous above.

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

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

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

(S) Maternity Coverage—Ten dollar (\$10) co-payment for initial visit. All other prenatal visits, delivery costs and routine post-natal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

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

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

(V) Outpatient Mental and Nervous Disorder—Ten dollar (\$10) co-payment per visit. Deductible and coinsurance do not apply to out-of-pocket maximum for out-of-network services. POS out-of-network limited to twenty-six (26) visits per calendar year.

(W) Oxygen (Outpatient)—Subject to twenty percent (20%) co-insurance. Covered under Durable Medical Equipment.

(X) Physical Therapy and Rehabilitation Services—Five dollar (\$5) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits may be allowed if showing significant improvement and recommended by case management.

(Y) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after ten dollar (\$10) co-payment per office visit.

(Z) Plan Maximum—Not applicable for network services in HMO/POS. POS out-of-network limited to three (3) million dollars with five thousand dollar (\$5,000) annual reinstatement.

(AA) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

1. Ten dollar (\$10) co-pay for thirty (30)-day supply for generic drug on the formulary.

2. Twenty dollar (\$20) co-pay for thirty (30)-day supply for brand drug on the formulary.

3. Thirty-five dollar (\$35) co-pay for thirty (30)-day supply for non-formulary drug.

4. Ninety (90)-day supply of medication for two (2) co-payments through mail order.

5. Prescriptions filled with a brand drug when a generic is available will be subject to the generic co-payment amount and the member must also pay the difference in cost between the generic and brand drugs.

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

(CC) Prosthetics—Provided in full for initial placement. Twenty percent (20%) coinsurance for coverage for repair or replacement due to change in medical condition or growth. Repair or replacement not covered out-of-network.

(DD) Skilled Nursing—Provided in full, limited to one hundred and twenty (120) days.

(EE) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full.

*AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective*

Jan. 1, 1998, expired June 29, 1998. Emergency amendment filed Feb. 23, 1998, effective March 5, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, terminated Jan. 14, 2000. Emergency amendment filed Jan. 4, 2000, effective Jan. 14, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.064 HMO/POS Standard Option Summary of Medical Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to the summary of medical benefits in the Missouri Consolidated Health Care Plan HMO and POS Standard Plans.

(1) Covered Charges.

(A) Allergy Injections—Twenty dollar (\$20) co-payment for office visit also covers injection. Ten dollar (\$10) co-payment per injection received if not during office visit.

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

(C) Birth Control Pills—Birth control pills on formulary covered at one hundred percent (100%). Oral contraceptives are not subject to coinsurance or co-payments.

(D) Chiropractic Benefits.

1. Health maintenance organization (HMO) and point-of-service (POS) in-network—Charges subject to twenty dollar (\$20) co-payment.

2. POS—Out-of-network services not covered.

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

(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restoration as a result of that injury.

(G) Durable Medical Equipment—Thirty percent (30%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.

(H) Emergency Care—Fifty dollar (\$50) co-payment in or out of service area. Waived if admitted.

(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a twenty dollar (\$20) co-payment.

(J) Growth Hormone Therapy—Thirty percent (30%) coinsurance. Subject to medical necessity and preauthorization.

(K) Hearing Aids and Testing—Covered once every two (2) years, subject to thirty percent (30%) co-payment and thirty dollar (\$30) co-payment for annual hearing test. POS non-network services not covered.

(L) Home Health Care—Covered when authorized by HMO or POS physician. POS non-network limited to sixty (60) annual visits.

(M) Hospice Care—Covered with prior authorization.

(N) Hospital Benefit for Mental and Nervous Disorder—Two hundred dollar (\$200) co-payment per admission. Eight hundred dollar (\$800) annual inpatient hospital maximum. Must have prior authorization.

(O) Hospital Benefits for Chemical Dependency—Two hundred dollar (\$200) co-payment per admission. Eight hundred dollar (\$800) annual inpatient hospital maximum. Must have prior authorization. Must be arranged by HMO or POS physician.

(P) Hospital Room and Board—Two hundred dollar (\$200) co-payment per admission. Eight hundred dollar (\$800) annual inpatient hospital maximum. Must have prior authorization. Must be arranged by HMO or POS physician.

(Q) Injections—All injections provided in full (except allergy and contraceptive injections).

(R) Infertility—Not covered.

(S) Maternity Coverage—Twenty dollar (\$20) co-payment for initial visit. All other prenatal visits, delivery costs and routine post-natal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.

(T) Organ Transplants—The following organ transplants covered at one hundred percent (100%): bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by HMO or POS. Donor expenses are covered as long as the patient is a member of the HMO or POS. No waiting periods allowed. POS out-of-network not covered.

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

(V) Outpatient Mental and Nervous Disorder—Twenty dollar (\$20) co-payment per visit. POS out-of-network services not covered.

(W) Oxygen (Outpatient)—Subject to thirty percent (30%) co-insurance. Covered under Durable Medical Equipment.

(X) Physical Therapy and Rehabilitation Services—Ten dollar (\$10) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits may be allowed if showing significant improvement and recommended by case management.

(Y) Physician Charges.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full after twenty dollar (\$20) co-payment per office visit.

(Z) Plan Maximum—Not applicable for network services in HMO/POS. POS out-of-network limited to one (1) million dollars.

(AA) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.

1. Ten dollar (\$10) co-pay for thirty (30)-day supply for generic drug on the formulary.

2. Twenty dollar (\$20) co-pay for thirty (30)-day supply for brand drug on the formulary.

3. Thirty-five dollar (\$35) co-pay for thirty (30)-day supply for non-formulary drug.

4. Ninety (90)-day supply of medication for two (2) co-payments.

5. Prescriptions filled with a brand drug when a generic is available will be subject to the generic co-payment amount and the member must also pay the difference in cost between the generic and brand drugs.

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

(CC) Prosthetics—Provided in full for initial placement. Thirty percent (30%) coinsurance for coverage for repair or replacement due to change in medical condition. Repair and replacement not covered out-of-network.

(DD) Skilled Nursing—Provided in full, limited to one hundred and twenty (120) days.

(EE) Surgery.

1. Inpatient—Provided in full.

2. Outpatient—Provided in full.

AUTHORITY: section 103.059, RSMo 2000.
Emergency rule filed Dec. 12, 2000, effective*

Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002.

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.065 Staff Model Summary of Medical Benefits

(Rescinded June 30, 2002)

AUTHORITY: section 103.059, RSMo 2000.
Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. Emergency rescission filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Rescinded: Filed Dec. 17, 2001, effective June 30, 2002.*

22 CSR 10-2.067 HMO and POS Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the limitations in the Missouri Consolidated Health Care Plan Staff Model and HMO/POS Plans.

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

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

(B) Acupuncture and biofeedback;

(C) Bone stimulators are not covered unless authorized by health maintenance organization (HMO) or point-of-service (POS);

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

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

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

(G) Custodial or domiciliary care;

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

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

(J) Hearing aids—limited to bilateral hearing aids every two (2) years;

(K) Hypnosis;

(L) In addition to any other listed limitations, out-of-network services in a POS are subject to the three hundred dollar (\$300) deductible and seventy/thirty percent (70/30%) coinsurance (premium), sixty/forty percent (60/40%) coinsurance (standard);

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

(N) Laetrile;

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

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

1. Reversal of voluntary sterilization;
2. *In vitro* fertilization;
3. Gamete intrafallopian transfer (GIFT);

and

4. Zygote intrafallopian transfer (ZIFT);

(Q) Non-growth related replacement of prostheses;

(R) Orthoptics;

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

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

(U) Personal comfort items;

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

(W) Physical fitness equipment;

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

(Y) Services not deemed to be medically necessary;

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

(AA) Services not specifically included as benefits are not covered;

(BB) Services provided by family or household members;

(CC) Skilled nursing services are limited to one hundred and twenty (120) days annually;

(DD) Smoking cessation patches and gum;

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

(FF) Transsexual surgery;

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

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

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

(JJ) Treatment for temporal mandibular joint (TMJ) dysfunction; and

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Amended: Filed Dec. 18, 1998, effective June 30, 1999. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.070 Coordination of Benefits

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

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

(2) As used in this rule—

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

1. A group or blanket plan on an insured basis;

2. Other plan which covers people as a group;

3. A self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;

4. A prepayment group plan which provides medical, vision, dental or health service;

5. Government plans, including Medicare;

6. Auto insurance when permitted by the laws of the state of jurisdiction; and

7. Single- or family-subscribed plans issued under a group- or blanket-type plan;

(B) The definition of plan shall not include:

1. Hospital preferred provider organization (PPO) type plans;

2. Types of plans for students; or

3. Any individual policy or plan;

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

(D) Allowable expense means a necessary, reasonable and customary item of medical, vision, dental or health expense which is covered at least in part under one of the plans. If a plan provides benefits in the form of services, the cash value of such service will be deemed to be the benefit paid. An allowable expense to a secondary plan includes the value or amount of any allowable expense which was not paid by the primary or first paying plan; and

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

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

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

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

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

(B) As to any benefit determination period, the allowable expense under this plan shall be coordinated, except as provided in subsection (3)(C) of this rule, so that the sum of such benefits and all of the benefits paid, payable or furnished which relate to such allowable

expense under other plans, shall not exceed the total of allowable expenses incurred by the covered individual. All benefits under other plans shall be taken into account whether or not claim has been made;

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

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

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

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

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

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

A. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody;

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

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

ers the person for the longer time shall be determined first; and

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

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

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

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

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

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

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

(B) Any insurance company; or

(C) Any other organization.

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

(10) If one of the other plans involved (as defined in coordination of benefits provision) provides benefits on an excess insurance or

excess coverage basis, subsections (3)(C) and (D) of this rule shall not apply to the plan and this policy will pay as excess coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.075 Review and Appeals Procedure

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

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

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

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

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

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

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

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

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

1. The hearing will be scheduled by the MCHCP.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Newborns—

(I) Notwithstanding any other rule, if a member currently has children coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within six (6) months of the child's date of birth. If a member does not currently have children coverage under the plan but states that the required information was provided within the thirty-one (31)-day enrollment period, he/she must sign an affidavit stating that their information was provided within the required time period. The affidavit must be notarized and received in the MCHCP office within thirty-one (31) days after the date of notification from the MCHCP; and

(II) Once the MCHCP receives the signed affidavit from the member, coverage for the newborn will be backdated to the date of birth, if the request was made within six (6) months of the child's date of birth. The approval notification will include language that the MCHCP has no contractual authority to require the contractors to pay for claims that are denied due to the retroactive effective date. If an enrollment request is made under

either of these two scenarios past six (6) months following a child's date of birth, the information will be forwarded to the MCHCP board for a decision.

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

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

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

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency amendment filed Dec. 12, 1997, effective Jan. 1, 1998, expired June 29, 1998. Amended: Filed Dec. 12, 1997, effective June 30, 1998. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expired June 28, 2000. Amended: Filed Dec. 6, 1999, effective May 30, 2000. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001. Emergency amendment filed Dec. 17, 2001, effective Jan. 1, 2002, expired June 29, 2002. Amended: Filed Dec. 17, 2001, effective June 30, 2002.*

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-2.080 Miscellaneous Provisions

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

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

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

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

ulent or redundant medical claims to either the Missouri Consolidated Health Care Plan, Missouri, or other public entities as an employer or self-insurer of Workers' Compensation for use in the investigation of a Workers' Compensation claim; or unless disclosure of the records is to the participant to whom the record pertains; or unless disclosure of the record is pursuant to the order of a court of competent jurisdiction. The parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity by a court of competent jurisdiction, may act on behalf of the individual.

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

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

*AUTHORITY: section 103.059, RSMo 2000. * Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. Emergency rescission and rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Rescinded and readopted: Filed Dec. 21, 1994, effective June 30, 1995. Emergency amendment filed Nov. 14, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Nov. 14, 1995, effective May 30, 1996. Emergency amendment filed Nov. 25, 1996, effective Jan. 1, 1997, expired June 29, 1997. Amended: Filed Nov. 25, 1996, effective May 30, 1997. Emergency rescission and rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Rescinded and readopted: Filed Dec. 12, 2000, effective June 30, 2001.*

**Original authority: 103.059, RSMo 1992.*