



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

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**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN**

Division 10—Health Care Plan

Chapter 3—Public Entity Membership

22 CSR 10-3.010 Definitions

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

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

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

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

(3) Administrative guidelines. Instructive interpretation of the plan document 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.

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

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

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

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

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

(7) Benefit period. The three hundred sixty-five (365) days immediately following the first date of like services.

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

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

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

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

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

(13) Claims administrator. An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans.

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

(15) Comprehensive major medical. A plan that provides for cost sharing to be applied to

all covered expenses such as deductible or coinsurance.

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

(17) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.

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

(19) Copay plan. A set of benefits similar to a health maintenance organization option.

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

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

(22) Covered benefits and charges. A schedule of covered services and charges payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.

(23) Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.

(24) Date of service. Date medical services are received or performed.

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



(26) Dependent-only participation. Participation of certain survivors of subscribers. Dependent participation may be further defined to include the deceased subscriber's:

- (A) Spouse only;
- (B) Child(ren) only; or
- (C) Spouse and child(ren).

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

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

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

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

- (A) Doctor of medicine;
- (B) Doctor of osteopathy;
- (C) Podiatrist;
- (D) Optometrist;
- (E) Chiropractor;
- (F) Psychologist;
- (G) Doctor of dental surgery; or
- (H) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

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

(32) Eligibility date. Refer to 22 CSR 10-3.020 for effective date provisions. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following

the employee's date of eligibility as determined by the employer.

(33) Emancipated child(ren). A child(ren) who is—

- (A) Employed on a full-time basis;
- (B) Eligible for group health benefits in his/her own behalf;
- (C) Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or
- (D) Married.

(34) Emergency. Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:

- (A) Conditions placing a person's health in significant jeopardy;
- (B) Serious impairment to a bodily function;
- (C) Serious dysfunction of any bodily organ or part;
- (D) Inadequately controlled pain; or
- (E) Situations when the health of a pregnant woman or her unborn child are threatened.

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

(36) Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-3.030(1)(A)7. Dependent participation may be further defined to include the participating employee's:

- (A) Spouse only;
- (B) Child(ren) only; or
- (C) Spouse and child(ren).

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

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

(39) Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge

of the offices, records, and employees of the plan, subject to the direction of the board.

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

- (A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;
- (B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or
- (C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

(41) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date the dependent meets the eligibility requirements for coverage under the plan.

(42) Formulary. A list of drugs covered by the pharmacy program claims administrator and as allowed by the plan administrator.

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

(44) Grievance. A written complaint submitted by or on behalf of a member regarding either:

- (A) Availability, delivery, or quality of health care services, including a complaint



regarding an adverse determination made pursuant to utilization review; or

(B) Claims payment, handling, or reimbursement for health care services.

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

(46) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference will be made available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook (January 1, 2010). It does not include any later amendments or additions.

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

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

(49) Home health agency. An agency certified by Medicare and the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.

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

(51) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered

person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

(52) Hospital.

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

(B) An institution not meeting all the requirements of (52)(A) above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

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

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

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

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

(53) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.

(54) Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.

(55) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this

plan, pregnancy is considered as any other illness.

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

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

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

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

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

(61) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.

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

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

(64) Lifetime maximum. The maximum amount payable by a medical plan during a covered member's life.

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

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

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

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

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or



supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

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

(68) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.

(69) Network provider. A physician, hospital, pharmacy, etc., that is contracted with the plan.

(70) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.

(71) Non-formulary. A drug not contained on the pharmacy program's formulary list but may be covered under the terms and conditions of the plan.

(72) Non-network provider or non-participating provider. Any physician, hospital, pharmacy, etc., that does not have a contract with the plan.

(73) 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.

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

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

(76) 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.

(77) Out-of-network. Providers that do not participate in the member's health or pharmacy plan.

(78) Out-of-pocket maximum. The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.

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

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

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

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

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric nurses and staff trained

to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

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

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

(84) Pharmacy benefit manager (PBM). Acts as a link between the parties involved in the delivery of prescription drugs to health plan members. The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

(85) 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.

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

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

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

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

(90) Plan year. Same as calendar year.

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

(92) Pre-certification. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or



diagnostic procedures (inpatient or outpatient).

(93) Pre-existing condition. A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.

(94) 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.

(95) Prevailing fee. The fee charged by the majority of dentists.

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

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

(98) Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the plan.

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

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

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

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

- (A) Date coverage was or will be terminated;
- (B) Reason for coverage termination; and
- (C) List of dependents covered.

(103) Prostheses. An artificial extension that replaces a missing part of the body. Prosthe-

ses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital) or to supplement defective parts.

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

(105) 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 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.

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

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

(108) 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.

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

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

(111) Refractions. A record of the patient's preference for the focusing of the eyes that can then be used to purchase eyeglasses. It is the portion of the eye exam that determines what prescription lens provides the patient with the best possible vision.

(112) Rehabilitation facility. A legally operat-

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

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

(113) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(6)(B) and is currently receiving a monthly retirement benefit from one (1) of the retirement systems listed in such rule.

(114) 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.

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

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

(A) 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;

(B) 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

(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in 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).

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

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

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

(120) State. Missouri.

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

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

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

(124) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.

(125) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument

or cutting procedure through any natural body opening or incision.

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

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

(128) Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

(A) Stepchild(ren);

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

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

(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

(E) Except for a disabled child(ren) as described in section (85) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-five (25) (see paragraph 22 CSR 10-3.020(4)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

(F) 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.

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

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

(131) Usual, Customary, and Reasonable Charge.

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

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

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

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

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

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions

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

(1) The participant's initial application, any subsequently accepted modifications to such application, the handbook, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any other written materials interpreting the subscriber agreement for the benefit of members and administrators are not part of the subscriber agreement.



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

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

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

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

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

(A) Employee Participation.

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

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

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if one (1) of the following occurs:

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Termination of employment;

B. Retirement; and

C. Termination of group coverage by the employer.

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

(C) Effective Date Provision.

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

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

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

2. The employer contributions toward the premiums cease; or

3. A dependent no longer qualifies due to age;

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

1. A Qualified Medical Child Support Order is received;

2. A dependent no longer qualifies for Medicaid; or

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

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

(A) Written request by the employee;

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

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

(D) Termination of Eligibility for Participation.

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



(5) and (6).

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

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

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

(6) Continuation of Coverage.

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

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

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

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

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

1. Eligibility Criteria:

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

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

C. Coverage since first eligible;

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

provision, may also continue coverage for eligible dependents.

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

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

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

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

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

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

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

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

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

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

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (subscriber only or subscriber and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (subscriber only or subscriber and dependents) upon returning to employment.

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



retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination.

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

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

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

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

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

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

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

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

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

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

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

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

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**Original authority: 103.059, RSMo 1992.*

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

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

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

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

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

2. The public entity shall contribute at

least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.045 Plan Utilization Review Policy

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

(1) Clinical Management—Certain benefits

are subject to a utilization review (UR) program. The program 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 claims administrator. For emergency hospital admissions, the claims administrator 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 claims administrator 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 who 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 (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits.

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges

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

(1) Non-network deductible amount—per individual for the Copay Plan each calendar

year, six hundred dollars (\$600); family limit each calendar year, one thousand two hundred dollars (\$1,200).

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

(A) Coinsurance is seventy percent (70%) after deductible is met when utilizing non-network providers.

(B) The deductible is waived and claims are paid at eighty percent (80%) for the following services: home health care, infusion, durable medical equipment (DME), and audiologists.

(C) Claims may also be paid at eighty percent (80%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(D) Non-network claims—are paid at seventy percent (70%) until two thousand four hundred dollars (\$2,400) has been met for an individual, four thousand eight hundred dollars (\$4,800) has been met for a family, of covered charges in the calendar year which are subject to coinsurance. Claims are paid at one hundred percent (100%) of any excess covered charges in the calendar year.

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

(A) Office visit—primary care: twenty-five dollars (\$25); specialist: thirty-five dollars (\$35).

(B) Laboratory and X-ray services—no copayment; covered at one hundred percent (100%).

(C) Inpatient hospitalizations—three hundred dollars (\$300) per admission; one thousand two hundred dollars (\$1,200) annual maximum inpatient copayment.

(D) Maternity—primary care: twenty-five dollars (\$25) for initial visit; specialist: thirty-five dollars (\$35).

(E) Preventive care—no copayment; covered at one hundred percent (100%).

(F) Outpatient surgery—one hundred dollars (\$100).

(G) Emergency room—one hundred dollars (\$100) network and non-network.

(H) Urgent care—thirty-five dollars (\$35) network and non-network.

(4) Out-of-pocket non-network maximum—the maximum amount payable by the participant



before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars (\$2,400); and

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

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

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

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

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

(B) Non-network claims—are paid at sev-

enty percent (70%) until the out-of-pocket maximum is met.

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

(D) Claims may also be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

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

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

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

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

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

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO

500 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, five hundred dollars (\$500); family limit each calendar year, one thousand five hundred dollars (\$1,500). Non-network: per individual each calendar year, one thousand dollars (\$1,000); family limit each calendar year, three thousand dollars (\$3,000).

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

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

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

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

(D) Claims may also be paid at ninety percent (90%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

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

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

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

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

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

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

(4) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent



(100%) of covered charges for the remainder of the calendar year.

(A) Network out-of-pocket maximum for individual—two thousand five hundred dollars (\$2,500).

(B) Network out-of-pocket maximum for family—seven thousand five hundred dollars (\$7,500).

(C) Non-network out-of-pocket maximum for individual—seven thousand dollars (\$7,000).

(D) Non-network out-of-pocket maximum for family—twenty-one thousand dollars (\$21,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

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

**Original authority: 103.059, RSMo 1992.*

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

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

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

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

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

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

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

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

(D) Claims may also be paid at ninety percent (90%) if required covered services are not available through a network provider within fifty (50) miles of the member’s home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

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

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

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

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

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

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

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

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

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

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

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

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copay-

ments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

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

**Original authority: 103.059, RSMo 1992.*

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

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

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

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

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

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

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

(D) Claims may also be paid at eighty percent (80%) if required covered services are not available through a network provider within fifty (50) miles of the member’s home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.



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

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

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

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

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

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

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

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

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

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

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

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

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

rule filed Jan. 4, 2010, effective June 30, 2010.

**Original authority: 103.059, RSMo 1992.*

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

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

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

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

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

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

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

(D) Claims may also be paid at eighty percent (80%) if required covered services are not available through network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

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

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

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

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

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

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the Usual, Customary, and Reasonable (UCR) limit; percentage amount coinsurance is reduced as a result of non-compliance with prior authorization; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

(5) Pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

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

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

22 CSR 10-3.060 PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, PPO 2000 Plan, HDHP, and Copay Plan Limitations

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, PPO 2000 Plan, HDHP, and/or Copay 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 within any of the sections of this rule.

(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency, or mental and nervous disorder that do not receive prior authorization as described in 22 CSR 10-3.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.

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

(4) Allergy services—no coverage for non-physician allergy services or associated



expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

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

(6) Autopsy.

(7) Blood storage, including whole blood, blood plasma, and blood products.

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

(9) Care received without charge.

(10) Comfort and convenience items.

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

(12) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets and supervision of medication that is usually self-administered.

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

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

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

(16) Examinations requested by a third party.

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

(18) Exercise equipment.

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

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

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

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

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

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

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

(26) Infertility—Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization). Those health services and associated expenses for the treatment of infertility are not covered, including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), *in vitro* fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer

(ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and non-medically necessary amniocentesis.

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

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

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

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

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

(30) Military service connected injury or illness.

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

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

(33) Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe morbid obesity as defined in 22 CSR 10-3.010 and satisfies all requirements described in the plan. Bariatric surgery will only be covered when prior authorization is received from the medical plan.

(A) Bariatric surgery additional qualifying criteria—

1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions will be considered based on clinical review;

2. Member must be eighteen (18) years of age or older;

3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt



must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;

4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;

5. Evidence the member and the attending physician have a life-long plan for compliance with lifestyle modification requirements;

6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and

7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.

(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.

(C) Revisions and corrections of bariatric procedures only when the revision is used to treat life-threatening complications (e.g. wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).

(34) Orthognathic surgery.

(35) Orthoptics.

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

keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

(37) Over-the-counter medications—except for insulin through the pharmacy benefit.

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

(39) Physical fitness.

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

(41) Private duty nursing.

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

(43) Services not specifically included as benefits.

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

(45) Stimulators (for bone growth)—not covered unless authorized by claims administrator.

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

(47) Temporomandibular Joint Syndrome (TMJ).

(48) Third-party examinations.

(49) Tobacco cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.

(50) Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.

(51) Transplants—travel expense—requires authorization from medical plan. Limited to

ten thousand dollar (\$10,000) maximum per transplant when accessing network services.

(52) Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.

(53) Travel expenses—not covered unless authorized by claims administrator.

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

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

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

(57) War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot, or other circumstances beyond the control of the plan.

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.070 Coordination of Benefits

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

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



(2) As used in this rule—

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

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

(B) The definition of plan shall not include:

1. Hospital preferred provider organization (PPO) type plans;
2. Types of plans for students; or
3. Any individual policy or plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. In spite of subparagraphs (3)(D)2.A. and B. of this rule, if there is a court decree which would otherwise decide financial duty for the medical, vision, dental or health care expenses for the child, the benefits of a plan which covers the child as a

dependent of the parent with such financial duty shall be decided before the benefits of any other plan which covers the child as a dependent; and when paragraphs (3)(D)1. and 2. of this rule do not establish the order of benefit determination, the plan which covers the person for the longer time shall be determined first; and

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

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

(5) If a member is eligible for Medicare due to a disability, Medicare is the primary plan and this plan is a secondary plan. If a member or dependent is eligible for Medicare due to end stage renal disease, this plan is primary for the first thirty (30) months. Medicare is primary after the first thirty (30) months.

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

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

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

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

(B) Any insurance company; or

(C) Any other organization.

(9) The claims administrator will pay benefits promptly, or, if applicable, within their contractual time frame obligations after submission of due proof of loss unless the claims administrator provides the claimant a clear, concise statement of a valid reason for further delay which is in no way connected with, or



caused by the existence of this provision nor otherwise caused by the claims administrator.

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

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

*Original authority: 103.059, RSMo 1992.

22 CSR 10-3.075 Review and Appeals Procedure

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

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

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

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

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

along with reasons why this information is necessary.

(5) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health plan contractor or claims administrator applicable to the member. Appeals to the health plan contractor or claims administrator must be made in writing within one hundred eighty (180) days of receiving the denial or notice which gave rights to the appeal. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan to review the decision of the health plan contractor or claims administrator.

(A) Appeals to MCHCP shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved. Administrative appeals shall be submitted in writing as soon as possible following written or verbal notice of an MCHCP staff denial of the member's administrative request. All appeals and administrative appeals shall be addressed to:

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

(B) The board may, in its discretion, choose to conduct a hearing regarding a member's appeal. If the board decides a hearing is needed to render a decision, it may utilize a hearing officer or committee to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law. In such cases—

1. The hearing will be scheduled by the MCHCP;

2. The parties to the hearing will be the insured and the applicable health plan or MCHCP staff in self-insured situations;

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; and

6. The 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 and solicit additional evidence and argument. It will review the summary of evidence and 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 as provided by Missouri law.

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

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

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

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

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

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

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

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

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to



non-payment (per lifetime of account).

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

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

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

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

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

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

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

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

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.080 Miscellaneous Provisions

PURPOSE: This rule establishes the policy of

the board of trustees in regard to miscellaneous provisions under the Missouri Consolidated Health Care Plan.

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

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

(3) Confidentiality of Records. The health records of the participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to the officers and employees of the plan or claims administrator or his/her legal representatives who have a need for the records in the performance of their duties; or unless disclosure would be for a routine use by the plan or claims administrator for a purpose which is compatible with the purpose for which it was collected; or unless disclosure of the

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

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

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

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

**Original authority: 103.059, RSMo 1992.*

22 CSR 10-3.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for Copay Plan, PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.

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

(A) Medications.

1. Network:

A. Generic: Eight dollar (\$8) copayment for up to a thirty (30)-day supply for



generic drug on the formulary;

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

C. Non-formulary: Fifty-five dollar (\$55) copayment for up to a thirty (30)-day supply for non-formulary drug;

D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;

E. Mail order program—

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for two and one-half (2 ½) regular copayments.

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

(a) Generic: six dollars and sixty-seven cents (\$6.67);

(b) Formulary brand: twenty-nine dollars and seventeen cents (\$29.17); and

(c) Non-formulary: forty-five dollars and eighty-three cents (\$45.83).

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

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

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

(3) Retail and mail order coverage includes the following (except for specialty drugs):

(A) Diabetic supplies, including:

1. Insulin;
2. Syringes;
3. Test strips;
4. Lancets; and
5. Glucometers;

(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;

(C) Prescribed self-injectables;

(D) Oral chemotherapy agents;

(E) Hematopoietic stimulants;

(F) Growth hormones with prior authorization;

(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and

(H) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar (\$500) annual benefit.

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

(A) First Step—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand-name drugs; and
3. Typically, a higher copayment amount is applicable.

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

(6) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan adminis-

trator. In order to file a claim, members must—

(A) Complete the claim form; and

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

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days supply.

(7) Formulary—The formulary does not change during a calendar year, unless—

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

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

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

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

**Original authority: 103.059, RSMo 1992.*