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

PROPOSED AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (5), (8), and (9).

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

PURPOSE: This amendment revises eligibility requirements, enrollment procedures, voluntary cancelation of coverage requirements, enrollment of a newborn child proof of eligibility procedures, disabled dependent documention timeframes and leave of absence form and payment timeframes.

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

(2) Eligibility Requirements.

(A) Active Employee Coverage.

1. An active employee may enroll him/herself and his/her spouse/child(ren) in one (1) of MCHCP's plans if s/he is an employee whose position is covered by the Missouri State Employees' Retirement System (MOSERS) or another retirement system whose members are grandfathered for coverage under the plan by law or is an eligible variable-hour employee of a MOSERS participating department or agency. The active employee is eligible to enroll in medical, dental, or vision coverage.

2. An active employee employed by the Missouri Department of Conservation and whose position is covered by MOSERS or who is an eligible variable-hour employee may only enroll him/herself and his/her spouse/child(ren) in an MCHCP dental or vision plan.

3. An active employee employed by the Missouri Department of Transportation or Highway Patrol may only enroll him/herself and his/her spouse/child(ren) in an MCHCP dental or vision plan if s/he is an employee whose position is covered by the Missouri Department of Transportation and Highway Patrol Employees' Retirement System (MPERS) or is an eligible variable-hour employee.

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

5. An active employee cannot be covered as an employee and as a dependent.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment. The employee may elect coverage for him/herself and his/her spouse/child(ren), provided the employee and his/her spouse/child(ren) have been continuously covered for health care benefits—

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

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of persons covered) is required.

2. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

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

5. If a retiree who is eligible for coverage elects not to be continuously covered for him/herself and spouse/child(ren) with MCHCP from the date first eligible, or does not apply for coverage for him/herself and spouse/child(ren) within thirty-one (31) days of his/her eligibility date, the retiree and his/her spouse/child(ren) shall not thereafter be eligible for coverage unless specified elsewhere herein.

6. An individual enrolled in another non-MCHCP **Medicare Advantage (Part C) and/or** Medicare Prescription Drug Plan (Part D) is not eligible for medical coverage.

(C) Survivor Coverage.

1. At the time of a vested active employee subscriber's death, his/her survivor(s) may elect to continue coverage if the survivor(s) had MCHCP coverage at the time of the subscriber's death. The deceased subscriber's spouse/child(ren) who do not have MCHCP coverage at the time of the death may elect MCHCP coverage and become a survivor if the spouse/child(ren) had coverage through group or individual medical coverage for the six (6) months immediately prior to the subscriber's death. In that case, proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of persons covered) is required.

2. At the time of a retiree or terminated vested subscriber's death, his/her survivor(s) may elect to continue coverage if the survivor(s) had MCHCP coverage at the time of the subscriber's death.

3. If a survivor subsequently marries and elects to add his/her new spouse to his/her coverage and the survivor dies, the new spouse's coverage ends at midnight on the last day of the month of the survivor's death (e.g., If the survivor dies November 3, new spouse's last day of coverage is November 30). Unless otherwise specified in this rule, the new spouse is not eligible to enroll for coverage at the time of the survivor's death.

4. If there are multiple survivors, once enrolled, the spouse will become the subscriber or, if there are only children, the youngest enrolled child will become the subscriber.

(D) Terminated Vested Coverage.

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

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

B. Through MCHCP since the initial date of eligibility; or

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

2. If a terminated vested employee does not elect coverage within thirty-one (31) days of their eligibility date, or if s/he cancels or loses his/her coverage or dependent coverage, the terminated vested employee and his/her dependents cannot enroll at a later date.

3. The terminated vested employee may temporarily continue coverage for him/herself and his/her dependents under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA).

4. Upon receiving an annuity or retirement benefit from MOSERS or PSRS, an enrolled terminated vested employee and his/her dependents will automatically continue coverage as a retiree.

5. Upon receiving a retirement benefit from Missouri Department of Transportation and Highway Patrol Employees' Retirement System (MPERS), an enrolled terminated vested employee shall notify MCHCP of his/her retirement status to continue coverage as a retiree.

(E) Long-Term Disability Coverage.

1. An employee is eligible for long-term disability coverage if the employee is eligible for long-term disability benefits from MOSERS or PSRS and the employee may elect or continue coverage if the employee with long-term disability coverage and his/her dependents or spouse/child(ren) had coverage—

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

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to becoming eligible for long-term disability benefits. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of persons covered) is required.

2. If an enrolled, vested, long-term disability subscriber becomes ineligible for disability benefits, the long-term disability subscriber and his/her dependents will have continuous coverage as a terminated vested subscriber. If an enrolled long-term disability subscriber is not vested, and becomes ineligible for disability benefits, coverage is terminated and the subscriber and his/her dependents are offered COBRA benefits. If an enrolled long-term disability subscriber becomes ineligible for disability benefits, and returns to work, the subscriber is considered a new employee and must enroll through Statewide Employee Benefit Enrollment System (SEBES).

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

4. Upon receiving an annuity or retirement benefit from MOSERS or PSRS, an enrolled long-term disability employee and his/her dependents will automatically continue coverage as a retiree.

5. Upon receiving a retirement benefit from MPERS, an enrolled long-term disability employee must notify MCHCP of his/her retirement status to continue coverage as a retiree.

(F) Terminated Non-Vested Elected State Official Coverage.

1. Terminated non-vested elected state officials (including members of the General Assembly and, state officials holding statewide office), terminated non-vested employees of elected state officials and their dependents may continue coverage in an MCHCP plan if employment terminates because the elected state official ceases to hold elected office. The elected state official or his/her employees must elect to continue coverage for themselves and dependents within thirty-one (31) days from the last day of the month in which employment is terminated. If the elected state official or his/her employees do(es) not elect coverage for him/herself and dependents within thirty-one (31) days, cancels, or loses his/her coverage or dependent coverage, the elected state official or his/her employees and his/her dependents cannot enroll at a later date.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

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

B. Active Employee Coverage of a Spouse.

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

C. Retiree Coverage of a Spouse.

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

(II) At retirement, an employee eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may enroll as a spouse under MCHCP;

2. Children.

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

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

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

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

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

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

(VIII) *[Newborn]***Child** of a dependent *[or child of a dependent when paternity by the dependent is established after birth so long as the parent is a dependent on the newborn's date of birth or the date the child's paternity was established and continues to be covered as a dependent of the subscriber;]* **as long as the parent is a dependent on the child's date of birth. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible.**

(IX) *[Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or]* **Child of a dependent when paternity by the dependent is established after birth as long as the parent is a dependent on the date the child's paternity was established. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's paternity establishment date for the child of the dependent to remain eligible.**

[(X) A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.]

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

(XI) A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(G), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

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

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

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov or through another designated enrollment system within thirty-one (31) days of his/her hire date or the date the employer notifies the employee that s/he is an eligible variable-hour employee. If enrolling a spouse or child(ren), proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period that runs October 1 through October 31 of each year.

3. An active employee may *[apply for]***elect or change** coverage for himself/herself and/or for his/her spouse/child(ren) 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee *[and]***or** his/her spouse/child(ren) may enroll within sixty (60) days *[if s/he]* **due to an** *[involuntarily]***involuntary** *[loses]* **loss of** employer-sponsored coverage under one (1) of the following circumstances:

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child, the active employee may enroll the child in an MCHCP plan within sixty (60) days of the court order.

4. **Default enrollment**

A. If an active employee is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the *[PPO 600]* **1250** Plan provided through the vendor the employee is enrolled in, effective the first day of the next calendar year.

*[A.]***B.** If an active employee is enrolled in the Health Savings Account (HSA) Plan *[(formerly High Deductible Health Plan)]***qualified high deductible health plan**. and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the HSA Plan at the same level of coverage.

*[B.]***C**. If an active employee is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

*[C.]***D**. Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

[5.] **E.** If an active employee is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[6.] **5.** If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss of** employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. *[If a retiree with Medicare is enrolled in the PPO 300 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 300 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.*

A. If a retiree with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.] **Default enrollment.**

A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the retiree does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

B. If a retiree with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period and has dependents who are not covered by Medicare his/her dependents without Medicare will be enrolled in the PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

*[B.]***C.** If a retiree without Medicare is enrolled in the PPO 300 Plan or PPO 600 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO *[600]***1250** Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

*[C.]***D.** If a retiree **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the retiree is enrolled in** at the same level of coverage**, effective the first day of the next calendar year**.

[(I) Retirees enrolled in the HSA Plan who become Medicare eligible or their dependents become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

*[D.]***E** If a retiree **without Medicare** is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage**, effective the first day of the next calendar year**.

[E. If a retiree is enrolled in the Medicare Prescription Drug Only Plan and does not complete enrollment during the open enrollment period, the retiree and his/her Medicare eligible dependents will be enrolled in the Medicare Prescription Drug Only Plan at the same level of coverage.]

6. If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C). Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]***due to an involuntary loss of** employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. **Default enrollment.**

A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the terminated vested subcriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the terminated vested subscriber does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year.

B. If a terminated vested subscriber without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO *[600]***1250** Plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year.

[A. If a terminated vested subscriber with Medicare is enrolled in the PPO 300 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 300 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

B. If a terminated vested subscriber with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]

C. If a terminated vested subscriber **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the terminated vested subscriber is enrolled in** effective the first day of the next calendar year, at the same level of coverage**, effective the first day of the next calendar year**.

[(I) Terminated vested subscribers enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

D. If a terminated vested subscriber **without Medicare** is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage**, effective the first day of the next calendar year**.

*[4.]***E.** If a terminated vested subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[5.]***4.** If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]***due to an involuntary loss of** employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. **Default enrollment.**

A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the long-term disability subcriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the long-term disability subscriber does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

B. If a long-term disability subscriber without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO *[600]***1250** Plan provided through the vendor the long-term disability subscriber is enrolled in, effective the first day of the next calendar year.

*[A.]***C.** If a long-term disability subscriber with Medicare is enrolled in the PPO 300 **or PPO 600** Plan and does not complete enrollment during the open enrollment period **and has dependents who are not covered by Medicare**, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO *[300]***1250** Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[B. If a long-term disability subscriber with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]

*[C.]***D.** If a long-term disability subscriber **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the long-term disability subscriber is enrolled in** at the same level of coverage**, effective the first day of the next calendar year**.

[(I) Long-term disability subscribers enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.

*D.]***E.** If a long-term disability subscriber **without Medicare** is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage**, effective the first day of the next calendar year**.

*[4.]***F.** If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

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

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

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may later add a spouse/child(ren) to his/her current coverage 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 MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]***due to an involuntary loss of** employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;
(II) Eligibility for employer-sponsored coverage ends;
(III) Employer contributions toward the premiums end; or
(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. **Default enrollment.**

A. A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

B. If a survivor without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO *[600]***1250** Plan provided through the vendor the survivor is enrolled in, effective the first day of the next calendar year.

[A.]**C.** If a survivor with Medicare is enrolled in the PPO 300 **or PPO 600** Plan and does not complete enrollment during the open enrollment period **and has dependents who are not covered by Medicare**, the survivor and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO *[300]***1250** Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[B. If a survivor with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

*C.]***D.** If a survivor **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the survivor is enrolled in** at the same level of coverage**, effective the first day of the next calendar year**.

[(I) Survivors who are enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.

*D.]***E.** If a survivor **without Medicare** is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents **without Medicare** will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage**, effective the first day of the next calendar year**.

*[5.]***F.** If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

*[6.]***5.** If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

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

(A) Employee and Dependent Effective Dates.

1. A new employee/eligible variable-hour employee and his/her dependents' coverage begins on the first day of the month after enrollment through SEBES or another designated enrollment system. Except at initial employment or when identified as an eligible variable-hour employee, an employee and his/her dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. Except for coverage being added due to a birth, adoption, or placement of children, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP. In no case, shall an eligible variable-hour employee and his/her dependents' coverage begin before January 1, 2015.

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

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date subject to receipt of proof of eligibility. The monthly premium is not prorated.

(II) If an active employee enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

B. Newborn.

(I) If a subscriber or employee enrolls an eligible newborn within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of the birth of the newborn, coverage becomes effective on the newborn's birth date or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated.

(III) If a subscriber does not elect to enroll a newborn of a dependent child within thirty-one (31) days of birth, s/he cannot enroll the newborn of a dependent at a later date;

C. Child where paternity is established after birth. If a subscriber enrolls a child within thirty-one (31) days of the date paternity is established, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

D. Adoption or placement for adoption.

(I) If a subscriber or employee enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption.

(II) If a subscriber or employee enrolls an eligible spouse and/or children within thirty-one (31) days of an adoption or placement for adoption, coverage may become effective on the date of adoption, or date of placement for adoption, or the first of the month after enrollment is received, subject to proof of eligibility. The monthly premium will not be prorated;

E. Legal guardianship and legal custody.

(I) If a subscriber or employee enrolls a dependent due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

F. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the subscriber or employee's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

G. Employee.

(I) If an employee enrolls due to a life event or loss of employer-sponsored coverage, the effective date for the employee is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

(II) If the life event is due to a birth, adoption, or placement of child(ren), coverage becomes effective on the newborn's birth date, date of adoption, or date of placement for adoption. The monthly premium will not be prorated.

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

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

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

5. An employee who terminates all employment with the state and is rehired in the following month and his/her eligible dependent(s) who were covered by the plan may choose to have continuous coverage or coverage the first of the month after his/her hire date if an enrollment form is submitted within thirty-one (31) days of hire date.

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

B. If the employee requests coverage to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

6. An employee who transfers in the same month from a state agency with MCHCP benefits to another agency with MCHCP benefits, and his/her eligible dependent(s) who were covered by the plan, will have continuous coverage. The employee must inform the former agency of the transfer in lieu of a termination. The employee will be transferred through eMCHCP by the former state agency's human resource or payroll representative to the new state agency.

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

7. For continuous coverage, an active employee who terminates employment with the state may transfer coverage of him/herself and his/her dependents, if eligible, to his/her spouse or parent who is an MCHCP subscriber if the spouse or parent completes an Enroll/Change/Cancel form within thirty-one (31) days of coverage termination of the active employee's employment.

8. An employee who transfers state employment from the Missouri Department of Transportation (MoDOT), Missouri State Highway Patrol, or the Department of Conservation and his/her dependents to another agency with MCHCP benefits will maintain his/her dental and/or vision coverage and may enroll in medical coverage within thirty-one (31) days of transfer. If enrollment is made within thirty-one (31) days of transfer, MCHCP medical coverage is effective with no break in coverage. Dental and vision coverage is continuous throughout the calendar year. An employee cannot enroll in dental and vision at the time of transfer if s/he was not enrolled prior to the transfer.

A. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event or loss of employer-sponsored coverage.

9. A state employee who has medical coverage under MCHCP and transfers state employment to MoDOT, Missouri State Highway Patrol, or the Department of Conservation and his/her dependents are no longer eligible for MCHCP coverage. MCHCP medical coverage is terminated the last day of the month of the employee's termination.

10. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(A) When enrolling a newborn **child**, the *[member]* **subscriber** must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the *[member]* **subscriber** of the steps to initiate coverage. The *[member]* **subscriber** is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date.

(B) Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Addition of biological child(ren)	Government-issued birth certificate or other government-issued or legally certified proof of paternity listing subscriber as parent and child's full name and birth date
Addition of stepchild(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Order of placement
Adoption of dependent(s)	Order of placement; or Filed petition for adoption listing subscriber as adoptive parent (documentation must be received with the enrollment forms) and final adoption decree or a birth certificate issued (documentation must be received within thirty-one (31) days of the date the court enters a final decree of adoption)
Legal guardianship or legal custody of dependent(s)	Court-documented guardianship or custody papers (Power of Attorney is not acceptable)
Addition of a child(ren) of covered dependent	Government-issued birth certificate or legally-certified proof of paternity for the child(ren) listing dependent as parent with child's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Government-issued death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified Medical Child Support Order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, length of coverage, reason for coverage termination, and list of persons covered
TRICARE Supplemental Coverage	Military ID Card

(C) An active employee, retiree, terminated vested subscriber, long-term disability subscriber, or survivor and all eligible spouse/child(ren) who qualify to receive a military ID card must submit a copy of their military ID card(s) to enroll in the TRICARE Supplement Plan.

(D) An employee and/or his/her spouse/child(ren) enrolling due to a loss of employer-sponsored group coverage. The employee must submit documentation of proof of loss within sixty (60) days of enrollment.

(E) A retiree, survivor, terminated vested subscriber, or long-term disability subscriber enrolling his/her spouse/child(ren) due to a loss of employer-sponsored group coverage. The retiree, survivor, terminated vested subscriber, or long-term disability subscriber must submit documentation of proof of loss for his/her spouse/child(ren) within sixty (60) days of enrollment.

(F) The employee is required to notify MCHCP on the appropriate form of the spouse's/child(ren)'s name, birth date, eligibility date, and Social Security number.

(G) Disabled Dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the **end of the month of the** dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(6) Military Leave.

(A) Military Leave for an Active Employee.

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

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for coverage under the Uniformed Services Employment & Reemployment Rights Act (USERRA). The agency payroll representative must notify MCHCP of the effective date of military leave. An employee who is on military leave is eligible for continued coverage for medical, vision, and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment after leave.

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

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

5. The employee must submit a form within thirty-one (31) days of the employee's return to work to be reinstated for the same level of coverage with the same plan as prior to the leave or if the employee was on military leave during open enrollment or while on military leave had a qualifying life event, the employee may change plans and add his/her spouse/child(ren). The employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work. The form and the official document must be submitted within sixty (60) days from the date of loss of coverage.

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

(B) Military Leave for a Retired Member.

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

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

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

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

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

6. If a retiree does not elect to continue USERRA coverage for his/her dependent(s), coverage ends effective the last day of the month in which the leave begins.

(7) Termination.

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

1. Failure to make any required contribution toward the cost of coverage.

A. Non-Medicare primary subscribers—If MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, the subscriber and his/her dependents will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period.

B. Medicare primary subscribers—If a Medicare primary subscriber fails to pay premiums by the required due date, MCHCP allows a sixty- (60-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the sixty- (60-) day grace period, coverage will be terminated effective the end of month in which the sixty- (60-) day grace period ends;

2. Entry into the armed forces of any country;

3. With respect to active employee(s) and his/her dependents, termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule;

4. With respect to active employee(s) and his/her dependents, the employer has determined that the active employee is no longer an eligible variable-hour employee;

5. With respect to dependents, upon divorce or legal separation from the subscriber or when a dependent is no longer eligible for coverage. A subscriber must terminate coverage for his/her enrolled ex-spouse and stepchild(ren) at the time his/her divorce is final.

A. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

6. Death of dependent. The dependent’s coverage ends on the date of death;

7. A member’s act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

8. A member’s threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP; or

9. A member otherwise loses benefit eligibility.

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

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

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

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the subscriber notifies MCHCP to cancel coverage.

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

2. A subscriber may reinstate medical coverage after a voluntary cancellation by submitting an Enroll/Change/Cancel form prior to the end of current coverage.

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

(C) A subscriber cannot cancel medical coverage on his/her dependents during a divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce. If premiums are collected pre-tax through the Missouri State Employees' Cafeteria Plan (MoCafe), medical coverage can only be cancelled at the time of divorce.

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

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage; *[or]*
4. When new coverage is taken through other employment*[.]***; or**
5. **When the member enrolls in Medicaid.**

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may continue participation in the plan by paying the required contributions. The employing department must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, Leave of Absence Enrollment form, and bill (if applicable) from MCHCP to continue coverage. If the completed form and payment (if applicable) are returned within *[ten (10)]***fourteen (14)** days of the date of the letter, coverage will continue. The employee will be set up on direct bill unless the employee and affected dependents are transferred to the plan in which his/her spouse is enrolled.

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

3. If the employee's spouse is an active employee or retiree, the employee and any dependents may transfer to the plan in which the spouse is enrolled if the transfer is elected on the Leave of Absence Enrollment form. Transfer is effective the first of the month following the date of leave. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

4. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage with MCHCP while on leave, may reenroll in his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave or if the employee was on leave of absence during open enrollment or while on leave of absence leave had a qualifying life event or loss of employer-sponsored coverage, the employee may change plans and add spouse/child(ren). When a leave of absence employee returns to work and MCHCP receives a state contribution for the month s/he returned, s/he will be charged the applicable active employee premium for that month. For coverage to be reinstated, the employee must submit a completed Enroll/Change/Cancel form within thirty-one (31) days of returning to work. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date.

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

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

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

2. If the employee cancels coverage, coverage ends on the last day of the month in which MCHCP received a premium payment.

3. If the employee canceled coverage, the employee may reinstate coverage by submitting a completed form within thirty-one (31) days of returning to work. Coverage will be reinstated with the same plan and level of coverage as enrolled in prior to the employee taking the leave of absence. If the employee was on FMLA leave during MCHCP's annual open enrollment, or if while the employee was on FMLA leave, the employee had a qualifying life event or loss of employer-sponsored coverage, the employee may change plans and add a spouse/child(ren) within thirty-one (31) days of returning to work.

4. If the employee continued coverage and is unable to return to work after his/her FMLA leave ends, his/her coverage will be continuous at the leave of absence rate or the employee may cancel coverage.

(C) Layoff. An employee on layoff status may continue participation in the plan by paying the required leave of absence premium for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. The employee will receive a letter, enrollment form, and bill from MCHCP. If the employee chooses to continue coverage, s/he must return the enrollment form and payment (if applicable) to MCHCP within ten (10) days of the date of the letter. If the employee continued coverage in a layoff status, and is two (2) months past due on his/her premiums, coverage on the employee and his/her dependents will be terminated at the end of the month payment was received. If the employee's spouse is an active state employee or retiree, the employee may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. If coverage terminates and the employee is recalled to service, eligibility will be as a new employee. If the employee returns to work with an agency covered by MCHCP, eligibility will be as a new employee. An employee and his/her spouse who is also a state employee must be covered individually.

(D) Workers' Compensation.

1. Coverage will automatically be extended to any subscriber who is on a leave of absence due to an illness or injury and receiving Workers' Compensation benefits. Coverage in the plan will be with the same plan and level of coverage (employee only or employee and dependents) and the member must continue to pay the premiums that were previously deducted from his/her paycheck.

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

3. If the subscriber is no longer eligible for Workers' Compensation benefits and does not return to work, then the subscriber's status is changed to leave of absence and the subscriber is direct billed the leave of absence premium.

(E) Reinstatement after Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action, s/he will be allowed to reinstate his/her medical benefit within thirty-one (31) days of his/her reinstatement as described below:

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

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

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

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

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

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

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

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, subscriber may add such eligible spouse/child(ren) to the subscriber's plan if MCHCP is notified within thirty-one (31) days of the marriage, birth, or adoption. The subscriber may also add eligible spouse/child(ren) during open enrollment.

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

4. A surviving dependent who has coverage due to the death of a non-vested employee, may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced or legally-separated enrolled spouse and stepchild(ren) may continue coverage at their own expense for up to thirty-six (36) months.

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

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage and the disability continues during the rest of the initial eighteen- (18-) month period of continuation of coverage, the member may continue coverage for up to an additional eleven (11) months.

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

(B) Premium Payments.

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

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

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

(C) Required Notifications.

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

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

3. If a COBRA member is disabled within the first sixty (60) days of COBRA coverage and the disability continues for the rest of the initial eighteen- (18-) month period of continuing coverage, the member must notify MCHCP that s/he wants to continue coverage within sixty (60) days, starting from the latest of: 1) the date on which the SSA issues the disability determination; 2) the date on which the qualifying event occurs; or 3) the date on which the member receives the COBRA general notice. The member must also notify MCHCP within thirty-one (31) days of any final determination that the individual is no longer disabled.

(D) Election Periods.

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) For a member to continue coverage under this subsection, a member must either:

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

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

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

1. A form for election to continue the coverage;

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

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

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

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

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

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

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

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

(12) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. If Medicare coverage begins before turning age sixty-five (65) years, the member will receive a Medicare disability questionnaire from MCHCP. The member must return the completed questionnaire to MCHCP for the Medicare eligibility information to be submitted to the medical vendor.

(13) Members are required to disclose to the claims administrator whether or not they have other health coverage and, if so, information about the coverage. A member may submit this information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied if the disclosure is not made. Once the information is received, claims will be reprocessed subject to all applicable rules.

(14) Communications to Members.

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

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

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

(D) Failure to update a mailing or email address may result in undeliverable mail/email of important informational material, delayed or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

(15) Deadlines. Unless specifically stated otherwise, MCHCP computes deadlines by counting day one (1) as the first day after the qualifying event. If the last day falls on a weekend or state holiday, MCHCP may receive required information on the first working day after the weekend or state holiday.

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PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

**Original authority: 103.059, RSMo 1992.*