MCHCP

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2017 Benefit Guide

State Members

Your health can be one of the most important things in your life. Knowing what choices you have when it comes to your health care can be difficult. That's where Missouri Consolidated Health Care Plan (MCHCP) can help.

We recognize that each of our almost 100,000 members are different and have unique needs. To meet those unique needs, MCHCP strives to offer a variety of options when it comes to benefits: from medical, prescription, dental and vision coverage to work-life balance programs and wellness incentives.

The 2017 MCHCP Benefit Guide was designed to help members understand these benefits and make informed decisions. This booklet outlines the plan options available and explains how each one works; all in an effort to educate you when it comes to your health care.

Medical
(HSA Plan and PPOs)

Prescription

Dental

Vision

SELF Program

Strive for Wellness® **Incentives**

Strive for Wellness® **Health Center**

Medical & Pharmacy Plan Overview

	Health Savings Account (HSA) Plan		PPO 600 Plan		PPO 300 Plan	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Deductible	$1,650/individual $3,300/family	$4,000/individual $8,000/family	$600/individual $1,200/family	$1,200/individual $2,400/family	$300/individual $600/family	$600/individual $1,200/family
Medical Out-of-Pocket Maximum	$3,300/individual $6,600/family	$5,000/individual $10,000/family	$1,500/individual $3,000/family	$3,000/individual $6,000/family	$1,500/individual $3,000/family	$3,000/individual $6,000/family
Prescription Out-of-Pocket Maximum	Combined with Medical		$5,100/individual $10,200/family	No Maximum	$5,100/individual $10,200/family	No Maximum
Preventive Services	MCHCP pays 100%	40% coinsurance	MCHCP pays 100%	30% coinsurance	MCHCP pays 100%	30% coinsurance
Office Visit	20% coinsurance	40% coinsurance	10% coinsurance	30% coinsurance	Primary Care or Mental Health: $25 copayment Specialist: $40 copayment Chiropractor: $20 copayment or 50% of total cost of service, whichever is less	30% coinsurance
Urgent Care	20% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance	$50 copayment	$50 copayment
Emergency Room	20% coinsurance	20% coinsurance	$100 copayment plus 10% coinsurance	$100 copayment plus 10% coinsurance	$100 copayment plus 10% coinsurance	$100 copayment plus 10% coinsurance
Hospital (Inpatient)	20% coinsurance	40% coinsurance	10% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Lab and X-ray	20% coinsurance	40% coinsurance	10% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Surgery	20% coinsurance	40% coinsurance	10% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Prescription Drugs*	Generic: 10% coinsurance Preferred: 20% coinsurance Non-Preferred: 40% coinsurance	Generic and Preferred: 40% coinsurance Non-Preferred: 50% coinsurance		**Days' Supply** 1-31 days 32-60 days 61-90 days (home delivery) 61-90 days (retail)	**Generic** $8 $16 $20 $24	**Preferred** $35 $70 $87.50 $105	**Non-Preferred** $100 $200 $250 $300

*Reduced coinsurance/copayments for certain diabetic medications and supplies. See page 23 for more information.

Medical Plans

Selecting the right medical plan is an important decision; one that can impact your finances. It's important to consider how the plans are similar, where they differ in cost, and which one is the right fit for you.

All three of MCHCP's medical plans – the Health Savings Account (HSA) Plan, the PPO 600, and the PPO 300 – offer the same, basic coverage, such as:

- 100% coverage of preventive care – such as annual wellness exams, vaccinations and age-specific screenings and much more – when using a network provider.
- Freedom to choose care from a nationwide network of primary care providers, specialists, pharmacies and hospitals, usually at a lower negotiated group discount.
- The same covered benefits for both medical and pharmacy.

While the benefits are the same in all three medical plans, other aspects differ – such as the premium, deductible and out-of-pocket (OOP) costs. Because each member has different medical needs, the best plan choice may differ from person to person. Take the time to consider your situation and review this section closely. It may help determine which plan is the right fit for you.

Preventive Services

Preventive services are designed to help identify potential health risks, allowing for early diagnosis and treatment. When done regularly, members not only save valuable time and money, but also experience better overall health outcomes.

Preventive care is covered at one hundred percent (100%) by MCHCP, regardless of your plan or whether you have met your deductible. For benefits to be covered at one hundred percent (100%), they must be supplied by a network provider, and billed as routine, without indication of an injury or illness.

Please talk with your provider about which preventive care services and health screenings are the most appropriate for you and your age group, as he or she is your best source of information about your health.

The preventive care benefit[1] includes, but is not limited to:

Adult

- Alcohol Misuse, Screening and Behavioral Counseling
- Annual Medical Exam
- Aspirin for the Prevention of Cardiovascular Disease
- Colorectal Cancer, Screening
- Depression in Adults, Screening
- Diabetes Mellitus, Screening
- Hepatitis C Virus Infection in Adults, Screening
- Immunizations
- Lung Cancer, Screening
- Obesity in Adults, Screening
- Routine lab and X-ray Services
- Skin Cancer, Counseling
- Tobacco Use in Adults, Counseling and Interventions

New in 2017

All non-Medicare members can receive four visits with a Certified Diabetes Educator[2] through their medical plan.

Men

- Abdominal Aortic Aneurysm, Screening

Women

- BRCA-Related Cancer in Women, Screening
- Breastfeeding, Counseling and Breast Pump
- Breast Cancer, Screening
- Cervical Cancer, Screening
- Osteoporosis, Screening

Children

- Well Child Exam – including depression, obesity, hearing and vision screenings and immunizations

MCHCP plans cover additional services as preventive care. For specific details, visit our website at **www.mchcp.org**.

1. Preventive services that are covered with no cost share are those services described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and HRSA Guidelines for women, as well as children, including the American Academy of Pediatrics Bright Futures periodicity guidelines.
2. Covered at 100 percent for PPO members or 100 percent after deductible is met for HSA Plan members, when received through a network provider. Visits must be ordered by a provider.

HSA Plan

Overview

The Health Savings Account (HSA) Plan is a qualified high-deductible plan. Members receive health coverage at a lower or no-cost premium, when compared to other MCHCP medical plans.

	Network	Non-Network
Preventive Services	MCHCP pays 100%	40% coinsurance
Deductible	$1,650 Individual $3,300 Family	$4,000 Individual $8,000 Family
Medical OOP Max	$3,300 Individual $6,600 Family	$5,000 Individual $10,000 Family
Prescription OOP Max	Combined with Medical	
Medical Services	20% coinsurance	40% coinsurance
Prescription Drugs*	Generic: 10% coinsurance Preferred: 20% coinsurance Non-Preferred: 40% coinsurance	Generic: 40% Coinsurance Preferred: 40% Coinsurance Non-Preferred: 50% coinsurance

*Reduced coinsurance/copayments for certain diabetic medications and supplies. See page 22 for more information.

The HSA offers several key advantages:

- Control: HSA funds accumulate to pay for IRS-qualified medical expenses, such as doctor and chiropractor fees, dental treatments, hospital bills, prescriptions and more. You decide how to spend it based on your health care needs and budget. Plus, HSA funds roll over from year to year; there is no "use-it-or-lose-it" policy. See page 16 for more information.
- Flexibility: You can deposit (as long as you remain eligible) or withdraw money any time. There is a yearly maximum amount for how much you can put in your account.
- Portability: You own the HSA funds and may keep them - even if you later change health plans, leave your job or retire.
- Tax Savings: There are triple tax savings with an HSA:

  1. You can put away money for qualified medical expenses before taxes are taken out. This means you set aside income-tax-free dollars in an HSA to pay for qualified medical expenses.
  2. Savings in your HSA grow tax-free.
  3. You pay no taxes when you use HSA funds to pay for qualified medical expenses.
- MCHCP Contribution: MCHCP will contribute to the HSAs of active employees. MCHCP will contribute $300 for individual coverage and $600 for family coverage. See page 16 for more information.

How the HSA Plan Works

1. Active employee opens an HSA through Central Bank. The bank will distribute a debit card, along with detailed information about the account.
2. Members may contribute to their HSA at any time. MCHCP will make an annual contribution to each active employee's HSA. Members are also encouraged to fund their account up to the annual limit set by the IRS (see chart on page 10). Active employees may contribute through voluntary payroll deductions. Retirees may contribute by making deposits directly with Central Bank.
3. Members may monitor their account through Central Bank's website and/or monthly activity statements.
4. When visiting any health care provider or pharmacy, the member may pay for their expenses using the HSA debit card. No claim forms are required.
5. There are no copayments with the HSA Plan. Members will pay all of their medical and prescription expenses, using their HSA funds or out of their pocket, until the annual deductible is met. The HSA may be used at any time for qualified expenses, as long as sufficient funds are available in the account.
6. Once the deductible is met, members will pay coinsurance on covered expenses until their out-of-pocket maximum is reached. At that time, the plan will begin paying 100 percent of covered services. See Family Coverage section on page 10.

2017 HSA Annual Contribution Limits

Contributions	Subscriber Only	Subscriber/Spouse Subscriber/Child(ren) Subscriber/Family
IRS Contribution Limit	$3,400	$6,750
IRS Contribution Limit (age 55 and older)	$4,400	$7,750
MCHCP Contribution (active employee subscribers only)	$300	$600
Active subscribers may contribute	$3,100	$6,150
Active subscribers may contribute (age 55 and older)	$4,100	$7,150

Contribution rules for HSAs are complex. Members should consult a tax advisor about individual circumstances and the maximum annual contribution. MCHCP does not provide individual tax advice.

Family Coverage

If two or more family members are covered in the HSA Plan, the family deductible must be met before the member begins paying applicable coinsurance. One covered family member's expenses may meet the entire family deductible.

Two married active state employees who cover children may participate in the Family Roll Up. This offering allows subscribers to combine their deductibles into one family deductible. For example, one spouse covers themselves and their children on a family plan, while the other spouse covers only themselves on an individual plan. With a Family Roll Up on the HSA Plan, this family would only have to meet one family deductible ($3,300), instead of a family deductible ($3,300) plus a separate individual deductible ($1,650).

Learn more about HSAs, and how they compare to a Flexible Spending Account (FSA), on pages 16-17.

Eligibility

To participate in an HSA Plan, subscribers cannot:

- Be claimed as a dependent on someone else's tax return.
- Be enrolled in another medical plan, including Medicare and TRICARE.
    - If the subscriber is an active employee and Medicare eligible, they must defer Medicare to participate.
    - If subscriber is retired and they or a covered dependent will be Medicare primary in the upcoming plan year, they cannot enroll in the HSA Plan during Open Enrollment.
    - A member may be enrolled in another qualified high deductible health plan, dental and/or vision plan.
- Be a retiree with a Medicare-eligible dependent.
- Have a health care flexible spending account (FSA) [excludes premium-only, Dental/Vision Health Care and dependent care portions] or a health reimbursement account (HRA).
- Have received medical benefits from the Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

See page 20 for information on the prescription drug coverage and coinsurance.

PPO 600 Plan

Overview

The PPO 600 Plan offers health coverage at a moderately priced premium, when compared to other MCHCP medical plans.

	Network	Non-Network
Preventive Services	MCHCP pays 100%	30% coinsurance
Deductible	$600 Individual $1,200 Family	$1,200 Individual $2,400 Family
Medical OOP Max	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Prescription OOP Max	$5,100 Individual $10,200 Family	No Maximum
Emergency Room	$100 copayment plus 10% coinsurance **Medicare:** 10% coinsurance	$100 copayment plus 10% coinsurance **Medicare:** 10% coinsurance
Other Medical Services	10% coinsurance	30% coinsurance

Emergency Room Copayment

Members visiting an emergency room (ER) may pay a $100 copayment. This copayment is waived if the member is admitted to the hospital or the services are considered by the medical plan to be a "true emergency." Even if the copayment is waived, the member will still have to pay any deductible or coinsurance owed for the ER service.

Copayments apply to the out-of-pocket maximum, but not the deductible. Medicare retirees will not owe copayments; they are only charged coinsurance.

How the PPO 600 Plan Works

1. When visiting a health care provider, the member will pay for their medical expenses out of their pocket until the annual deductible is met. Members visiting an emergency room may also pay a $100 copayment (see Emergency Room Copayment section on page 12).
2. Once the deductible is met, members will pay coinsurance on covered expenses until their out-of-pocket maximum is reached. At that time, the plan will begin paying 100 percent of covered services (see Family Coverage section below).
3. Active employees with a health care Flexible Spending Account (FSA) may receive reimbursement for qualified medical expenses by submitting a claim and providing necessary documentation to MOCafe. See page 16 for more information.

See page 20 for information on the prescription drug coverage and copayments.

Family Coverage

If two or more family members are covered in a PPO plan and one family member reaches the individual deductible or out-of-pocket maximum, the medical plan begins paying claims for the individual. If one or more additional family members meet the individual deductible or out-of-pocket maximum, the medical plan begins paying claims for the entire family.

Two married active state employees who cover children may participate in the Family Roll Up. This offering allows subscribers to combine their deductibles into one family deductible. For example, one spouse covers themselves and their children on a family plan, while the other spouse covers only themselves on an individual plan. With a Family Roll Up on the PPO 600 Plan, this family would only have to meet one family deductible ($1,200), instead of a family deductible ($1,200) plus a separate individual deductible ($600).

PPO 300 Plan

Overview

The PPO 300 Plan offers health coverage at a higher premium, when compared to other MCHCP medical plans.

	Network	Non-Network
Preventive Services	MCHCP pays 100%	30% coinsurance
Deductible	$300 Individual $600 Family	$600 Individual $1,200 Family
Medical OOP Max	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Prescription OOP Max	$5,100 Individual $10,200 Family	No Maximum
Office Visit[1]	**Primary Care or Mental Health:** $25 copayment **Chiropractor[2]:** $20 copayment **Specialist:** $40 copayment **Medicare:** 10% coinsurance	30% coinsurance **Medicare:** 10% coinsurance
Urgent Care	$50 copayment **Medicare:** 10% coinsurance	$50 copayment **Medicare:** 10% coinsurance
Emergency Room	$100 copayment plus 10% coinsurance **Medicare:** 10% coinsurance	$100 copayment plus 10% coinsurance **Medicare:** 10% coinsurance
Other Medical Services	10% coinsurance	30% coinsurance

1. The office visit copayments cover the visit only. Any lab, X-ray or other services associated with the visit will apply to the deductible and coinsurance.
2. Chiropractor copayment may be less than $20 if it is more than 50 percent of the total cost of the service.

See page 20 for information on the prescription drug coverage and copayments.

Copayments

Members will pay a copayment for office visits, urgent care and emergency room (ER) services. The ER copayment is waived if the member is admitted to the hospital or the services are considered by the medical plan to be a "true emergency." Even if the copayment is waived, the member will still have to pay any deductible or coinsurance owed for the ER service.

Copayments apply to the out-of-pocket maximum, but not the deductible. Medicare retirees will not owe copayments; they are only charged coinsurance.

How the PPO 300 Plan Works

1. When visiting a health care provider, the member will pay a copayment for each visit. The member will also pay for other medical expenses out of their pocket until the annual deductible is met (see Copayments section above).
2. Once the deductible is met, members will continue to pay copayments. However, members will now pay coinsurance on covered expenses until their out-of-pocket maximum is reached. At that time, the plan will begin paying 100 percent of covered services (see Family Coverage section below).
3. Active employees with a health care Flexible Spending Account (FSA) may receive reimbursement for qualified medical expenses by submitting a claim and providing necessary documentation to MOCafe. See page 16 for more information.

Family Coverage

If two or more family members are covered in a PPO plan and one family member reaches the individual deductible or out-of-pocket maximum, the medical plan begins paying claims for the individual. If one or more additional family members meet the individual deductible or out-of-pocket maximum, the medical plan begins paying claims for the entire family.

Two married active state employees who cover children may participate in the Family Roll Up. This offering allows subscribers to combine their deductibles into one family deductible. For example, one spouse covers themselves and their children on a family plan, while the other spouse covers only themselves on an individual plan. With a Family Roll Up on the PPO 300 Plan, this family would only have to meet one family deductible ($600), instead of a family deductible ($600) plus a separate individual deductible ($300).

HSA vs. FSA

Active employees are encouraged to fund their medical expenses by setting up either a Health Savings Account (HSA) or a health care Flexible Spending Account (FSA). Both accounts allow members to deposit and withdraw money tax-free[1] for qualified medical expenses.

The accounts differ in the following areas:

- The types of health plans they work with
- MCHCP's contribution amount
- Whether or not unused funds can be rolled over
- The reimbursement process

Review the chart on the following page to determine which account is best for you.

Question	Health Savings Account (HSA) Plan	Flexible Spending Account (FSA)
Which plan must a subscriber enroll in to have this account?	HSA Plan	PPO 600 or PPO 300
Who contributes?	Subscriber and MCHCP	Subscriber
What is MCHCP's contribution?[2]	Subscriber Only: $300 All Other Levels: $600	$0
What are the maximum annual contribution limits for 2017?	Subscriber Only: $3,400 All Other Levels: $6,750	$2,550 per subscriber
What happens at the end of the year?	Unused balance rolls over.	Subscriber can incur expenses up to March 15 the following year. Any balance remaining at the end of this grace period is forfeited; budget conservatively.
What happens if a subscriber leaves their job?	Subscriber keeps their account and may continue to use the funds for qualified expenses.	Subscriber may submit expenses for reimbursement until April 15 of the following year. Expenses must have been incurred during time of employment.
What is the reimbursement process?	Use HSA debit card for qualified expenses.	Submit a claim form and provide documentation to MOCafe. Claims may be submitted via mail, fax, mobile app or online.
What are the tax benefits?[1]	Contributions can be taken from paycheck on a pre-tax basis (before taxes are withheld) and are tax-deductible. Withdrawals for qualified medical expenses are tax-free.	Contributions are taken from paycheck on a pre-tax basis (before taxes are withheld). Claim reimbursements for qualified medical expenses are tax-free.

1. MCHCP does not provide tax advice. We recommend consulting a tax advisor for more information.
2. Active employees only. Must also have a zero balance in your health care FSA if transitioning from a PPO plan.

Transitioning from an FSA to an HSA

Subscribers cannot be in a health care FSA and be eligible for an HSA at the same time. Subscribers may, however, participate in the HSA and a Dental/Vision Health Care FSA (formerly known as the Limited Scope Health Care FSA).

In order to receive HSA contributions from MCHCP, a subscriber's health care FSA must first have a zero balance. Subscribers with a remaining balance in their health care FSA on December 31 will wait longer to receive their HSA contribution the following year. Subscribers have until April 15 (the following year) to claim expenses through their FSA. MCHCP will make its annual contribution to the HSA in April rather than in January. If a subscriber does not have an outstanding balance in their health care FSA on December 31, MCHCP will make its annual contribution in January.

Deadlines to remember

Date	Description
December 31	FSA must have a zero balance in order to receive the MCHCP HSA contribution in January.
January	MCHCP contribution will be deposited into HSA if FSA has a zero balance on December 31.
March 15	Date of service deadline for any FSA remaining funds to be used for qualified expenses. Funds that are not used by this date will be forfeited.
April	MCHCP contribution will be deposited into HSA if there were remaining FSA funds on December 31.
April 15	Deadline to submit claims for remaining FSA funds. Funds that are not claimed by this date will be forfeited.

Prescription Drug Plan

100 Percent Coverage

There are certain medications that MCHCP will cover at 100%[1], when accompanied by a prescription and filled at a network pharmacy:

- Preferred[2] birth control (non-preferred may be covered in limited situations)
- Generic vitamin D, 1,000 IU or less
- Over-the-counter (OTC) nicotine replacement therapy
- Preferred[2] brand and generic quit tobacco medications for members aged 18 and over
- Generic Tamoxifen, generic Raloxifene, and brand Soltamox (Tamoxifen liquid for patients who have difficulty swallowing Tamoxifen tablets) for the prevention of breast cancer
- Generic Aspirin, 81mg for women up to age 55 with preeclampsia risk
- Generic Aspirin, up to 325mg for men 45-79 years of age and women 55-79 years of age for the prevention of cardiovascular events
- Generic Folic Acid, 400 to 800 mcg/ day for women up to age 50
- Generic bowel prep (preferred[2] and OTC)
- Influenza vaccination – members aged 6 months and over
- Shingles vaccination – members aged 50 and over (pharmacists in Missouri may only be able to administer the vaccination to those aged 60 and over)
- Fluoride for children aged 6 months through 12 years
- Iron Supplement for members aged 6 months through 12 months

1. Drugs covered at 100% are those described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and HRSA Guidelines for women, as well as children, including the American Academy of Pediatrics Bright Futures periodicity guidelines.
2. Preferred drug as determined by ESI.

For information, visit our website at **www.mchcp.org**.

Prescription Plan for Non-Medicare Members

Non-Medicare members automatically receive prescription coverage with MCHCP medical plan enrollment. Express Scripts, Inc. (ESI) administers the benefits and offers a broad choice of covered drugs through a nationwide pharmacy network. Subscribers will receive a separate prescription ID card upon enrollment.

Drug Formulary and Exclusions

A drug formulary is a list of FDA-approved generic and brand-name prescription drugs and supplies covered by your health insurance plan. ESI places covered drugs into three levels: preferred generic, preferred brand or non-preferred.

Preferred drugs are covered at a lower cost to you. Non-preferred drugs are covered, but you will pay more than if you choose preferred brand or preferred generic drugs. If your health care provider prescribes a non-preferred drug, discuss preferred alternative options with your provider.

There are some drugs that are not covered. These drugs have a covered alternative option that can be discussed with your provider. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price. Your provider may request a clinical exception to cover the drug by calling Express Scripts' Prior Authorization Line. Approved exceptions are covered as a non-preferred drug.

ESI's preferred formulary list is available on the MCHCP website or by contacting ESI, and can change throughout the year. If you have a question about a drug you take, please call ESI at 800-797-5754.

Description	Health Savings Account (HSA) Plan	PPO Plans
Retail — Network (Up to 31-day supply)		
Generic	10% coinsurance	$8
Preferred	20% coinsurance	$35
Non-Preferred	40% coinsurance	$100
Retail* — Network (32- to 60-day supply)		
Generic	10% coinsurance	$16
Preferred	20% coinsurance	$70
Non-Preferred	40% coinsurance	$200
Retail* — Network (61- to 90-day supply)		
Generic	10% coinsurance	$24
Preferred	20% coinsurance	$105
Non-Preferred	40% coinsurance	$300
Home Delivery — Network (61- to 90-day supply)		
Generic	10% coinsurance	$20
Preferred	20% coinsurance	$87.50
Non-Preferred	40% coinsurance	$250
Retail — Non-Network (Up to 31-day supply)		
Generic	40% coinsurance	$8
Preferred	40% coinsurance	$35
Non-Preferred	50% coinsurance	$100
	Pay full price of prescription and file claim. Members are reimbursed the network discounted amount, less the applicable copayment or coinsurance	

*May not be available at all retail locations.

Prescription Plan for Non-Medicare Members

Home Delivery and Retail Pharmacy

Members taking maintenance medications must decide whether to receive their prescriptions by home delivery or retail pharmacy. The home delivery benefit covers up to a 90-day supply for 2½ copayments.

Members may fill a maintenance prescription twice at a retail pharmacy while they decide. If the member has not notified ESI of their choice by the third fill of the prescription, the member must pay the full network discounted amount for the prescription.

Specialty Medications

Specialty medications are drugs that treat chronic, complex conditions. They require frequent dosage adjustments, clinical monitoring, specialty handling, and are often unavailable at retail pharmacies.

Accredo is ESI's home delivery specialty pharmacy provider. Specialty drugs must be filled through Accredo. If ESI has identified your medication as being needed immediately, you may get the first fill at a retail pharmacy. After that first fill, you must get that specialty medication through Accredo. Members who continue to go to a retail pharmacy will be charged the full discounted price of the specialty drug.

Diabetes Support Services

Non-Medicare members needing diabetic medications or supplies can receive the following:

- Lower prescription copayments/coinsurance (see chart on page 23)
- Preferred glucometer (one per year), and prescribed preferred test strips and lancets*

**Covered at 100 percent for PPO members or 100 percent after deductible is met for HSA Plan members, when received through a network pharmacy.*

HSA Plan Coinsurance for Diabetic Medications			
	Generic	**Preferred**	**Non-Preferred**
Network	5% coinsurance	10% coinsurance	20% coinsurance
Non-Network	20% coinsurance	20% coinsurance	25% coinsurance

PPO Plan Copayments for Diabetic Medications			
Supply	**Generic**	**Preferred**	**Non-Preferred**
Up to 31-day	$4	$17.50	$50
Up to 60-day	$8	$35	$100
Up to 90-day (Home Delivery)	$10	$43.75	$125
Up to 90-day (Retail)	$12	$52.50	$150

Other Information

Some prescriptions are subject to preauthorization, quantity level limits or step therapy requirements. If you fail to follow requirements, the prescription may not be covered.

More information about prescription drug coverage can be found on our website at **www.mchcp.org**.

Prescription Plan for Non-Medicare Members

How the Non-Medicare Prescription Plan Works

1. The member receives a prescription from a health care provider.
2. Fill the prescription. Depending on the medication, members have several options in which to fill their prescriptions:
    a. Short-term medications can be filled at a retail pharmacy.
    b. Members taking ongoing, maintenance medications must decide whether they would like to fill it at a retail pharmacy or through ESI's Home Delivery. See section on page 22 for more information.
    c. Specialty medications must be filled through Accredo, ESI's home delivery pharmacy provider (see Specialty Medications section on page 22 for more information).
3. Pay for prescription. Drug costs are based on the drug tier (preferred* brand or generic, or non-preferred) and where the prescription was filled (retail pharmacy or home delivery). PPO Plan members pay a set copayment. HSA Plan members pay the full cost of the prescription until deductible is met. After that, they pay coinsurance (see chart on page 21 for more information).
    a. Some prescriptions are covered at 100 percent (see section on page 19 for more information).
4. Members will continue to pay prescription copayments/coinsurance until their out-of-pocket maximum is reached. At that time, the plan will begin to pay 100% of covered expenses. For PPO Plans, the prescription and medical out-of-pocket maximums are separate. For the HSA Plan, the prescription and medical out-of-pocket maximum is combined.

**Preferred drug as determined by ESI.*

Prescription Plan for Medicare Members

The Medicare Prescription Drug Plan is a Medicare Part D Plan with expanded prescription coverage. Express Scripts Medicare Prescription Drug Plan (PDP) administers the benefits.

Medicare members have two options:

1. Medical with prescription coverage. Eligible members will automatically be enrolled in the Express Scripts Medicare PDP when they enroll in a medical plan. Non-Medicare eligible dependents will remain in the non-Medicare prescription drug plan.
2. Prescription-only coverage. Medicare primary retirees have the option of choosing MCHCP coverage for prescription drugs only, without MCHCP medical coverage. This allows members to shop the competitive Medicare market to supplement Medicare coverage.

Subscribers will receive a separate prescription ID card upon enrollment.

Network and Coverage

Express Scripts Medicare PDP maintains a nationwide pharmacy network. Members must use the network pharmacies to fill prescriptions. Covered Medicare Part D drugs are available at non-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. Members may have to pay additional costs for drugs received at non-network pharmacies.

This plan maintains a broad choice of covered drugs through the Medicare PDP formulary. The drug formulary is a list of FDA-approved generic and brand-name prescription drugs and supplies covered by your health insurance plan. ESI places covered drugs into three levels: preferred generic, preferred brand or non-preferred.

Preferred drugs are covered at a lower cost to you. Non-preferred drugs are covered, but you will pay more than if you choose preferred brand or preferred generic drugs. If your health care provider prescribes a non-preferred drug, discuss preferred alternative options with your provider.

There are some drugs that are not covered. These drugs have a covered alternative option that can be discussed with your provider. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price. Your provider may request a clinical exception to cover the drug by calling Express Scripts' Prior Authorization Line. Approved exceptions are covered as a non-preferred drug.

The formulary list is available on the MCHCP website or by contacting ESI, and can change throughout the year.

Members can fill a prescription from any physician at a network pharmacy or through home delivery and may receive up to a 90-day supply of certain maintenance drugs.

Members will receive additional plan information directly from Express Scripts Medicare, including a benefit overview, formulary, pharmacy directory and monthly explanations of benefits.

Description	Tier	Home delivery three-month (90-day) supply	Retail one-month (31-day) supply	Retail two-month (60-day) supply	Retail three-month (90-day) supply
Initial Coverage Stage	**Tier 1** Preferred Generic drugs	$20 copayment	$8 copayment	$16 copayment	$24 copayment
	Tier 2 Preferred drugs	$87.50 copayment	$35 copayment	$70 copayment	$105 copayment
	Tier 3 Non-preferred drugs	$250 copayment	$100 copayment	$200 copayment	$300 copayment
Coverage Gap Stage (Donut Hole)	After annual drug costs reach $3,700 members will continue to pay the same cost-sharing amount as in the Initial Coverage stage until annual out-of-pocket drug costs reach $4,950.				
Catastrophic Coverage Stage	After annual out-of-pocket drug costs reach $4,950, members will pay **the greater of 5% coinsurance *or***: • A $3.30 copayment for covered preferred generic drugs (including preferred drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage Stage. • A $8.25 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage Stage.				

How the Medicare Prescription Plan Works

1. The member receives a prescription from a health care provider.
2. Fill the prescription at a network pharmacy. Depending on the medication, members have several options in which to fill their prescriptions:
    a. Short-term medications can be filled at a retail pharmacy.
    b. Members taking ongoing, maintenance medications may decide whether they would like to fill it at a retail pharmacy or through ESI's Home Delivery (see Network and Coverage section on pages 25-26 for more information).
3. Pay for prescription. Copayments are based on the drug tier (preferred* brand or generic, or non-preferred), the Coverage Stage level (Initial, Coverage Gap or Catastrophic) and where the prescription was filled (retail pharmacy or home delivery). See the chart on page 26 for more information.
    a. Some prescriptions are covered at 100 percent (see section on page 19 for more information).

**Preferred drug as determined by ESI.*

TRICARE Supplement Plan

Military members can choose the TRICARE Supplement Plan, administered by Selman & Company, instead of MCHCP medical and pharmacy benefits. The TRICARE Supplement Plan works with TRICARE, the Department of Defense's health benefit program for the military community.

To be eligible, the member must be a non-Medicare active state employee, retiree, terminated vested subscriber or survivor and have TRICARE.

Features include:

- Fully employee paid by pre-tax dollars through payroll deduction
- No deductibles
- No copayments or coinsurance
- Ability to use civilian physicians

A copy of subscriber's military ID is required to enroll in the TRICARE Supplement Plan. Enrolled subscribers may enroll eligible dependents in the plan. Dependent military IDs must also be submitted, if issued.

For more information about the plan and to determine eligibility, contact Selman & Company.

Dental Plan

Overview

Delta Dental of Missouri (DDMO) offers comprehensive dental benefits through a nationwide network of participating providers. These benefits include:

- Diagnostic and preventive care services
- Basic and restorative services
- Major services

How the Dental Plan Works

1. The member may visit a network or non-network provider.
    a. DDMO offers two provider networks: the Delta Dental PPO Network and the Delta Dental Premier Network. Both networks offer members cost-control and claim-filing benefits. However, out-of-pocket expenses may be higher with the Delta Dental Premier Network.
    b. If utilizing a non-network provider, the member will be responsible for paying the provider in full, as well as submitting a claim form to DDMO. The out-of-pocket costs will most likely be higher.
2. The cost of the visit will also depend on the type of service the member received.
    a. Diagnostic and preventive services are covered at 100%.
    b. Members receiving basic and restorative or major services must meet a $50 deductible. Once the deductible is met, members will pay coinsurance (see chart on page 31 for more information).
3. Coverage is limited to $1,000 per person per calendar year.

The chart below provides a summary of the covered services.

Coverage	Service	You Pay	Note
Diagnostic and Preventive	Examinations Prophylaxes (teeth cleaning) Fluoride Bitewing X-rays Sealants	No deductible 0% coinsurance	Dental exams, X-rays, cleanings and fluoride treatment do not apply to the individual plan maximum
Basic and Restorative	Emergency Palliative Treatment Space Maintainers All Other X-rays Minor Restorative Services (fillings) Simple Extractions	$50/person deductible[1] 20% coinsurance	X-rays do not apply to the individual plan maximum
Major Services	Prosthetic Device Repair All Other Oral Surgery Periodontics Endodontics Prosthetic devices (bridges, dentures) Major Restorative Services (crowns, inlays, onlays) Implants/Bone Grafts	$50/person deductible[1] 50% coinsurance	12-month waiting period for major services. The waiting period is waived with proof of 12 months of continuous dental coverage for major services immediately prior to the effective date of coverage in MCHCP's Dental Plan

1. Coinsurance amounts apply after the $50 individual deductible is met under either Basic and Restorative or Major Services combined.

The cost of dental insurance is paid by the employee/retiree. Two additional cleanings are allowed per calendar year for members who are pregnant, diabetic, have a suppressed immune system or have a history of periodontal therapy.

Visit the MCHCP website for more information.

Vision Plan

Overview

National Vision Administrators, L.L.C. (NVA) offers vision benefits through a nationwide network of participating providers. Basic and premium plans are offered with specific copayments for services from network proivders. Both plans offer allowances for services from non-network providers. These plans do not replace medical coverage for eye disease or injury.

The chart below provides a summary of the copayments and reimbursement rates for the two vision plans.

Benefits	Network	Non-Network
Exams - once every calendar year **Two annual exams covered for children up to age 18**		
Vision Exam	$10 copayment	Reimbursed up to $45
Lenses - once every calendar year; copayment applies to all lens options		
Single-vision lenses **(per pair)**	$25 copayment	Reimbursed up to $30
Bifocal lenses (per pair)	$25 copayment	Reimbursed up to $50
Trifocal lenses (per pair)	$25 copayment	Reimbursed up to $65
Lenticular lenses (per pair)	$25 copayment	Reimbursed up to $100
Polycarbonate lenses (per pair) **Applies to children up to age 18**	100% coverage	Not covered
Premium Plan Only Standard anti-reflective coating	$30 copayment	Not covered
Premium Plan Only Standard progressive multifocal	$50 copayment	Not covered

Benefits	Network	Non-Network
Frames — once every two calendar years; once every calendar year for children up to age 18		
Frames[1]	**Basic Plan**	
	Up to $125 retail allowance and 20% discount off remaining balance Up to $55 Every Day Low Price price point at Wal-Mart or Sam's Club locations (if included in the network). Discount off remaining balance does not apply at Wal-mart or Sam's Club locations.	Reimbursed up to $70
	Premium Plan	
	Up to $175 retail allowance and 20% discount off remaining balance Up to $77 Every Day Low Price price point at Wal-Mart or Sam's Club locations (if included in the network). Discount off remaining balance does not apply at Wal-mart or Sam's Club locations.	Reimbursed up to $70
Contact Lenses - once every calendar year in place of eye glass lenses		
Elective[1] If member prefers contacts to glasses Retail allowances may be used over multiple visits in the same calendar year.	**Basic Plan**	
	Up to $125 retail allowance and 15% discount off conventional or 10% discount off disposable remaining balance Up to $92 Every Day Low Price price point for contact lenses at Wal-Mart or Sam's Club locations (if included in the network). Discount off remaining balance does not apply at Wal-mart or Sam's Club locations.	Contact lenses reimbursed up to $105

Benefits	Network	Non-Network
Contact Lenses continued		
	Premium Plan	
Elective[1] If member prefers contacts to glasses Retail allowances may be used over multiple visits in the same calendar year.	Up to $175 retail allowance and 15% discount off conventional or 10% discount off disposable remaining balance Up to $129 Every Day Low Price price point for contact lenses at Wal-Mart or Sam's Club locations (if included in the network). Discount off remaining balance does not apply at Wal-mart or Sam's Club locations.	Contact lenses reimbursed up to $105
Necessary If medically necessary with prior approval from National Vision Administrators, L.L.C. (NVA)	Additional costs covered at 100%	Contact lenses reimbursed up to $210
Fitting and Evaluation	$20 copayment for daily contact lenses; $30 copayment for extended contact lenses; $50 copayment for specialty contact lenses	Reimbursed up to $20 for daily contact lenses; $30 copayment for extended or specialty contact lenses
Other		
EyeEssential Discount Plan	When members exhaust their annual benefits, NVA offers the EyeEssential Discount Plan, which provides significant discounts on materials through participating NVA network providers.	Not covered

Benefits	Network	Non-Network
LASIK Discounts	NVA members will pay a maximum amount for corrective laser surgery: • Traditional PRK – $1,500 per eye • Traditional LASIK – $1,800 per eye • Custom LASIK – $2,300 per eye Members may receive additional benefits at LasikPlus locations nationwide: • Special pricing on select technologies • Free initial consultation and comprehensive LASIK vision exam • Advanced laser technologies including Wavefront and IntraLase (All-Laser LASIK) • Financing options available	Not covered

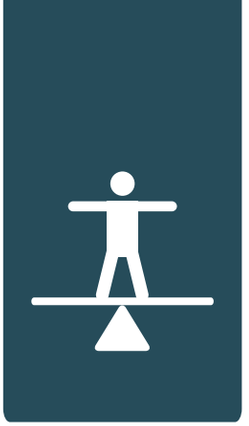
1. **Wal-Mart and Sam's Club Example**: A member with the Premium Plan chooses a pair of frames at Wal-Mart that cost $128. The Premium Plan pays $77, and the member pays the $51 difference.

How the Vision Plan Works

1. The member may visit a network or non-network provider.
2. If using a network provider, the member will pay a vision exam copayment plus the applicable cost for materials purchased.
   a. Most lenses and contact lenses have a copayment.
   b. Members needing frames or elective contact lenses will receive a retail allowance. This allowance varies between the Basic and Premium Vision Plans.
   c. See the chart on pages 32-35 for more information.
3. If using a non-network provider, the member will be responsible for paying the provider in full, as well as submitting a claim form to NVA. NVA will then reimburse the member up to specific amount. This amount is based on the member's vision plan (Basic or Premium) as well as the service and/or materials purchased. See chart on pages 32-35 for more information.
4. Cost maximums are available to members needing corrective laser surgery through NVA's LASIK discount program.
5. When a member exhausts their annual benefits, they may still receive significant discounts on materials through NVA's EyeEssential Discount Plan.

The cost of vision insurance is paid by the employee/retiree. When receiving services from a network provider, NVA pays the provider directly. When receiving services from a non-network provider, members pay the provider and file the claim. Reimbursement checks for non-network claims may take up to 30 days to process. In Missouri, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

Visit the MCHCP website for more information.



Strive Employee Life & Family (SELF) Program

Personal problems, planning for big life events or dealing with daily stress can affect your overall well-being. The Strive Employee Life & Family (SELF) program, previously called the Employee Assistance Program (EAP), is here to help. The SELF program, offered through ComPsych, is your place to help reduce stress, improve health and enhance life balance. Plus, the SELF program is offered at no cost to you!

State employees eligible for MCHCP medical coverage and members of their household may use the SELF program 24 hours a day, every day of the year. You can keep using the SELF program for 18 months following retirement and through the month after you are laid off. Your household members can use the SELF program for six months after your death.

Local, Private, In-Person Counseling

The SELF program offers behavioral health counseling services to help with everyday issues such as stress, relationships, parenting, grief and loss and substance use. Trained staff will listen to your concerns and refer you to a local counselor for in-person help.

You can get up to six counseling sessions per problem, per year, per person. There is no limit on the number of different problems. Additional counseling sessions may be covered by an MCHCP medical plan.

Money Matters

The SELF program offers FinancialConnect® for phone sessions with a Certified Public Accountant or Certified Financial Planner. These experts can help you with a wide range of money issues, including how to get out of debt, retirement planning, and saving for college.

Legal

The SELF program offers LegalConnect® for phone sessions with an attorney. You can talk with an attorney to ask questions, get legal help and plan next steps. For in-person legal help, LegalConnect® will refer you to a local attorney for a 60-minute session and a 25 percent discount for additional time.

Identity Theft and Fraud Resolution

The SELF program offers IDResources® for a phone session with a fraud resolution specialist and legal and financial experts. You can get a 60-minute session to help with identity theft or fraud and to restore damaged credit.

Everyday Support

The SELF program offers FamilySource® for help with every day issues such as child and elder care, moving and relocation, making major purchases, vacation planning and much more. You can call or go online to get expert help. FamilySource® staff will listen to you and then they take it from there to create a plan for getting the services you need.

This plan will be done within two business days, but could be within 24 hours depending on your needs. Your plan will be sent by e-mail, fax or mailed second day air right to you. The plan will include advice specific to your needs such as:

- At least three local referrals with maps and directions to each
- Specific state-licensing standards for facilities and providers
- Checklists to help review facilities and providers

Online Library of Helpful Tools

The SELF program offers GuidanceResources® Online for more information and advice. This tool includes an on-line library that covers topics such as health, wellness, consumer, family, career, education, as well as legal and finance. You can also use the "Ask a Guidance Consultant" feature to find the information you need.

Strive for Wellness® Program

Strive for Wellness®, MCHCP's wellness program, is designed to encourage members to get and stay healthy. The program offers voluntary activities, such as quit tobacco and weight management courses, health educator exhibits, an annual 5K event, and more.

Strive for Wellness® also offers lower medical premiums for participation in the Partnership Incentive and Tobacco-Free Incentive programs.

The Partnership Incentive

The Partnership Incentive of $25 per month is available to non-Medicare subscribers who do not have the TRICARE Supplement Plan. To receive the Incentive of $25 per month, members must complete the Partnership Promise, online Health Assessment and Health Education Quiz through their myMCHCP account.

Eligible members can earn the Incentive at any time throughout the year. The Incentive begins the first day of the second month after the required steps are completed. Participants who complete the required steps before Nov. 30, 2016, will begin receiving the Incentive on Jan. 1, 2017. New employees adding medical coverage with an effective date on or after Dec. 1, 2016, must complete the required steps within 31 days of their effective date for the Incentive to begin the same date that coverage begins.

Incentive participants may receive a T-shirt upon reporting the completion of an MCHCP-approved health action. Examples of MCHCP-approved health actions include receiving an annual preventive exam, attending two *Strive for Wellness®* lunch-and-learns, or walking 1,000,000 steps.

The Tobacco-Free Incentive

The Tobacco-Free Incentive of $40 per month per person is available to non-Medicare subscribers and their covered non-Medicare spouses. Qualifying members must be enrolled in an MCHCP medical plan, and not have the TRICARE Supplement Plan.

Eligible members can earn the Incentive at any time throughout the year.

Members who are tobacco-free, meaning they have not used tobacco in the past three months and will not use tobacco, can complete the Tobacco-Free Promise form.

Members who are NOT tobacco-free can complete the Quit Tobacco Promise form. MCHCP will mail these members a Quit Tobacco Road Map, a self-help guide with resources and tips to improve chances of quitting. Members can also download the Quit Tobacco Road Map through their myMCHCP account.

The Incentive begins the first day of the second month after the required steps are completed. Members who complete the required steps before Nov. 30, 2016, will begin receiving the Incentive on Jan. 1, 2017.

For newly eligible members, the Incentive may begin on the same day that medical coverage is effective, so long as the member completes the necessary steps, as described above, within 31 days of their medical coverage effective date. If these required steps are not completed within 31 days of the medical coverage effective date, then the Incentive will begin on the first day of the second month after the steps are completed.

MCHCP plans include 100 percent coverage for preferred* brand and generic quit tobacco medications and over-the-counter nicotine replacement therapy with a prescription. To learn more, call ESI at 800-797-5754.

**Preferred drug as determined by ESI.*

Notice Regarding the *Strive for Wellness®* Program

Strive for Wellness® is a voluntary program available to active Missouri state employees with Missouri Consolidated Health Care Plan (MCHCP) medical coverage. The *Strive for Wellness®* Program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health assessment (HA) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., diabetes, or heart disease). You are not required to complete the HA.

However, eligible subscribers who choose to participate in the wellness program will receive a premium reduction of $25 monthly for agreeing to participate in the Partnership Incentive, completing the HA and a Health Education Quiz. Although you are not required to complete the HA or the Health Education Quiz, only employees who do so will receive the Partnership Incentive of $25 a month.

Partnership Incentive participants can receive a t-shirt for completing a health-related activity such as an annual preventive exam or regularly exercising. If you are unable to participate in any of the MCHCP-approved health-related activities you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting MCHCP at 800-487-0771.

The information from your HA will be used to provide you with information to help you understand your current health and potential risks. You are encouraged to share your HA results or concerns with your health care provider.

Protections from Disclosure of Medical Information

MCHCP is required by law to maintain the privacy and security of your personally identifiable health information. Although the *Strive for Wellness®* Program and MCHCP may use aggregate

information it collects to design a program based on identified health risks in the workplace, *Strive for Wellness*® will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the *Strive for Wellness*® Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the *Strive for Wellness*® Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment or health benefits.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the *Strive for Wellness*® Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the *Strive for Wellness*® Program or receiving the Partnership Incentive. Anyone who receives your information for purposes of providing you services as part of the *Strive for Wellness*® Program will abide by the same confidentiality requirements. The only individuals who will have access to your personally identifiable health information are MCHCP Information Technology and Clinical Staff and only if accessing your personally identifiable health information is needed to potentially provide you with services under the *Strive for Wellness*® Program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, the identity of information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the *Strive for Wellness*® Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact MCHCP Member Services at 800-487-0771.

Strive for Wellness® Health Center

The *Strive for Wellness®* Health Center brings basic health care to active state employee subscribers enrolled in an MCHCP medical plan. The Center offers routine care for common illnesses and basic preventive care at hours designed to fit into a hectic workday. It is conveniently located in Jefferson City's Harry S Truman Building. Parking passes for reserved spaces are available.

Examples of services include:

- Treatment of sinus and ear infections, flu and allergies
- Vaccines such as flu, Hepatitis B, meningitis and shingles
- Health screenings

The office visit fee covers the services for the entire visit and is as follows:

- PPO plans have a $15 office visit fee
- HSA Plan has a $45 office visit fee
- Preventive services are covered at 100 percent

Cash, check or major credit cards are accepted. Payment is due at the time of the appointment.

Health Center services are outside the MCHCP medical plan benefits. Fees do not apply toward the medical plan's deductible or out-of-pocket maximum.

To schedule an appointment, call 573-526-3175 or log in to your myMCHCP account.

Contact Information

Who to Contact

Your plan for:

Claim questions
ID Cards
Specific benefit questions
Appeal information

MCHCP for:

General benefit questions
Eligibility questions
Enrollment questions
Address changes or forms
MCHCPid requests
HIPAA forms and questions

Medical Plan

UMR
HSA Plan, PPO 600, and PPO 300
www.umr.com
888-200-1167

Claims Address
PO Box 30787
Salt Lake City, UT 84130-0787

Appeals Addresses
Pre-service and Concurrent Claims
UMR Appeals
PO Box 400046
San Antonio, TX 78229

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

Medical Plan

Aetna
HSA Plan, PPO 600, and PPO 300
www.aetna.com
800-245-0618

Claims Address
PO Box 14079
Lexington, KY 40512-4079

Appeals Address
Appeals Resolution Team
PO Box 14463
Lexington, KY 60512

Prescription Plan for Non-Medicare Members

Express Scripts, Inc. (ESI)
www.express-scripts.com
800-797-5754
TTY: 866-707-1862

Home Delivery Pharmacy Service
PO Box 66773
St. Louis, MO 63166-6773

Appeals Address
Express Scripts
PO Box 66588
St. Louis, MO 63166-6588
Attn: Clinical Appeals Department
800-753-2851

Prescription Plan for Medicare Members

Express Scripts Medicare
www.express-scripts.com
866-544-6963
TTY: 800-716-3231

Medicare Home Delivery Pharmacy Service
PO Box 66577
St. Louis, MO 63166-9843

Appeals Address
Express Scripts
PO Box 66588
St. Louis, MO 63166-6588
Attn: Medicare Clinical Appeals
800-935-6103

Accredo Specialty Pharmacy
800-903-8224
TTY: 877-804-9222

Dental Plan
Delta Dental
www.deltadentalmo.com/stateofmo
866-737-9802

Claims Address
PO Box 8690
St. Louis, MO 63126-0690

Appeals Addresses
First-Level Appeals Address
Attn: Customer Service
12399 Gravois Road
St. Louis, MO 63127

Second-Level Appeals Address
Attn: Appeals Committee
12399 Gravois Road
St. Louis, MO 63127

Vision Plan
National Vision Administrators, L.L.C. (NVA)
www.e-nva.com
User Name: mchcp
Password: vision1
877-300-6641

Claims Address
Attn: Claims
PO Box 2187
Clifton, NJ 07015

Appeals Address
Attn: Complaints, Grievances & Appeals
PO Box 2187
Clifton, NJ 07015

Strive for Wellness® Program
Quit Tobacco and Weight Management Programs
www.mchcp.org

Attn: Wellness Department
832 Weathered Rock Court
Jefferson City, MO 65110
Member Services: 573-751-0771
Toll-free: 800-487-0771

Strive for Wellness® Health Center
www.my.mchcp.org
301 W. High St.
Jefferson City, MO
573-526-3175

TRICARE Supplement Plan
Selman & Company
www.selmantricareresource.com/MCHCP
800-638-2610

SELF Program
ComPsych®
www.guidanceresources.com
800-808-2261

Nurse Call Lines
All MCHCP medical plan members have access to 24-hour nurse call lines for health-related questions.

If you're unsure whether to go to the doctor for an illness or just want more information about a treatment or condition, registered nurses are on hand all day, every day to help.

To use this service, call your medical plan:

UMR NurseLine
888-200-1167

Aetna – Informed Health Line
800-556-1555

Helpful Tips
Websites
Plan websites are provided as a convenience to our members. The inclusion of other websites does not mean MCHCP endorses or is responsible for those websites.

Provider Directories
Participating providers may change during the year. Contact the plan or the provider to verify participation. Contact UMR, Aetna, ESI, DDMO or NVA for a list of network providers.

Benefit Information
This guide provides a summary of your benefits. More detailed information is available at www.mchcp.org or from the plans.

Discrimination is Against the Law

MCHCP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MCHCP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MCHCP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Shelley Farris.

If you believe that MCHCP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Shelley Farris
Director of Benefit Administration
832 Weathered Rock Court, PO Box 104355
Jefferson City, MO 65110
Phone/Fax: 573-526-3427
Compliance@mchcp.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Shelley Farris (Director of Benefit Administration) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-487-0771 (TTY: 1-800-735-2966).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-487-0771 (TTY: 1-800-735-2966).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-487-0771 (TTY: 1-800-735-2966).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-487-0771 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-735-2966).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-487-0771 (TTY: 1-800-735-2966).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-487-0771 (رقم هاتف الصم والبكم: 1-800-735-2966).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-487-0771 (телетайп: 1-800-735-2966).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-487-0771 (TTY: 1-800-735-2966) 번으로 전화해 주십시오.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-487-0771 (ATS: 1-800-735-2966).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-487-0771 (TTY: 1-800-735-2966).

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-487-0771 (TTY: 1-800-735-2966).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-487-0771 (መስማት ለተሳናቸው: 1-800-735-2966).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-487-0771 (TTY: 1-800-735-2966).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-487-0771 (TTY: 1-800-735-2966) تماس بگیرید.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-487-0771 (TTY: 1-800-735-2966).

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