

2020 Procedures Manual

for Public Entity Human Resources/Payroll Personnel

Introduction

Use this manual, the Benefit Guide and code of state regulations at 22 CSR 10-3 to learn about employee health benefits through Missouri Consolidated Health Care Plan (MCHCP) and the requirements for a public entity to remain with MCHCP.

As MCHCP guidelines change, this manual is updated. Your suggestions and comments are welcome and appreciated because you provide a vital link between public entity employees and MCHCP.

Table of Contents

4-9 | Contact Information

Plan Contact Information	4
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10-13 | Eligibility

Definitions.....	5
Employee Classification	5
Eligibility Requirements	5-6
Participation Levels.....	6-7
Contribution Levels.....	7
Eligibility Changes	8
Termination Policy	8

14-18 | Enrollment

Waiving Coverage.....	9
New Employees.....	9
Dual Coverage	9
Transfers	9
Terminations.....	10
Open Enrollment	10
Notifying MCHCP of Changes	10
COBRA.....	10-11
Certificates of Coverage.....	11

17-18 | Billing

Payment and Refund of Premium	12
Understanding your Bill	12
ACH Payment Option.....	13
Delinquent Account Policy	13

Plan Contact Information

MCHCP

Missouri Consolidated
Health Care Plan
www.mchcp.org
800-487-0771 or 573-751-0771
TTY: 800-735-2966
Fax: 866-346-8785

Monday – Friday
8:30 a.m. – 4:30 p.m.
(excluding state holidays)

832 Weathered Rock Court
PO Box 104355
Jefferson City, MO 65110–4355

Medical Plan

Anthem Blue Cross and Blue
Shield
www.anthem.com
844-516-0248 (Member
Services) 866-962-1395 (24/7
NurseLine)

Monday - Friday
7:00 a.m. - 6:00 p.m.

Claims Address

PO Box 105187
Atlanta, GA 30348

Dental Plan

MetLife
www.metlife.com/mchcp
844-222-9106

Monday - Friday
7:00 a.m. - 10:00 p.m.

Claims Addresses

Attn: MetLife Dental Claims
PO Box 14588
Lexington, KY 40512

Vision Plan

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

24 hours a day

Claims Address

Attn: Claims
PO Box 2187
Clifton, NJ 07015

Strive Employee Life & Family (SELF) Program

CompPsych®
www.guidanceresources.com
800-808-2261

To access services, visit
myMCHCP or call MCHCP
Member Services

Prescription Drug Plan

Express Scripts, Inc. (ESI)
www.express-scripts.com
800-797-5754

24 hours a day

Home Delivery Pharmacy Service

PO Box 66773
St. Louis, MO 63166-6773

Claims Address

Express Scripts
Attn: Commercial Claims
PO Box 2872
Clinton, IA 52733-2872
Fax: 608-741-5475

Accredo Specialty Pharmacy

800-803-2523
TTY: 877-804-9222

Eligibility

Definitions

Throughout MCHCP publications, including this manual, we frequently use the following terms:

- **Subscriber** - The employee or survivor who elects coverage under the plan
- **Member** - Any person covered as either a subscriber or a dependent in accordance with an employee benefit plan
- **Health Plans** - Any medical, dental, vision or employee assistance plans offered by MCHCP

Employee Classification

- **Active** - Employees eligible to receive health insurance benefits. The public entity may set a minimum average number of hours worked per year to establish eligibility. This classification may include: full-time, part-time, seasonal, long-term disability (LTD), leave of absence employees, and elected/appointed officials while in office.

Employees under this classification appear on the bill as active employees and receive active employee premiums. If a public entity is responsible for the salary and taxes of seasonal employees, seasonal employees may be eligible for benefits

- **Retiree** - A retiree is defined as a former employee who, at the time of retirement, is receiving an annuity benefit from an entity-sponsored retirement system
- **Survivor** - A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or a retiree of a public entity with a retirement system. Survivors may be eligible to continue coverage if they meet the eligibility criteria and the public entity employer continues coverage with MCHCP
- **Dependent Children** - Generally, when a dependent child turns 26, the participant-only COBRA premium applies, not the child-only premium. The child-only premium applies when an employee

terminates employment and continues coverage on his or her children through COBRA. Children may be covered up to the end of the month in which they turn 26.

Children age 26 or older may continue coverage if they became permanently disabled prior to age 26. New employees may add eligible disabled dependents as long as the disability occurred prior to age 26, with proof of eligibility.

Eligibility Requirements

The following sections explain eligibility requirements and other pertinent information for public entities participating with MCHCP.

Employees and Dependents

Health plans contracted with MCHCP must be made available to all eligible employees and their dependents. An eligible employee is actively employed and meets the minimum number of hours worked per year as established by his or her employer. If the public entity allows elected/appointed officials to participate in the health plans, they are considered eligible employees. MCHCP provides coverage for existing COBRA participants until their eligibility period expires or until the public entity terminates coverage with MCHCP, whichever occurs first. The entity determines some eligibility guidelines, such as probationary periods, required number of working hours, pay status and contribution level.

Retirees and their Dependents

The health plans must be made available to all retirees and their dependents. The entity must make the benefits available to all retirees who meet the vesting requirements. Retirees remain eligible as long as the entity remains with MCHCP. Employees may continue on COBRA if they are not eligible retirees or if they do not wish to continue coverage as a retiree.

Eligibility

Retirement System Definition

For an eligible employee to continue coverage as a retiree, a retirement plan must be in place. If neither of these scenarios is applicable and no retirement plan exists, employees are ineligible for retiree health benefits. Below are two types of retirement plan options recognized by MCHCP:

- An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. Under this option, the employer must offer coverage to retirees who meet the minimum vesting requirement
- An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to that of the Missouri State Employees' Retirement System (MOSERS). If this criterion is not met, the employer may not offer coverage to that person as a retiree

Participation Levels

A specific number of employees are required to participate within a plan for the public entity to offer health benefits.

Audits

Audits will be conducted annually to ensure entities meet these requirements.

To verify participation, each entity must provide a copy of its *Missouri Quarterly Contribution and Wage Report* annually with the *Selection of Offerings* form. Proof of other coverage for those waiving coverage will also be required.

Medical Plan

In determining an entity's participation level, MCHCP excludes eligible employees who waive coverage through MCHCP because they have other group coverage. Other group coverage includes TRICARE, an employer-sponsored health plan, Medicare or Medicaid (MO HealthNet). Proof of other coverage is required to exclude employees when calculating the participation level.

MCHCP shall be the only medical option available to the entity's employees, their dependents and retirees.

Employers with three or fewer employees are not subject to the 75 percent participation requirement.

Employers with four or more eligible employees must maintain 75 percent of all eligible employees participating in the medical plan.

EXAMPLE: Public Entity A has 125 eligible employees on the payroll. Twenty-five of those employees do not participate in the plan, but they have coverage through plans offered by their spouses' employers. This leaves a total of 100 eligible employees. MCHCP requires that 75 of these employees participate in the medical plan.

Dental Plan

The public entity is required to maintain medical participation requirements to offer the dental plan. A subscriber and his or her dependents may enroll in the dental plan even if the subscriber waives medical coverage. The subscriber must enroll in dental for his or her dependents to participate. The subscriber's level of coverage for dental does not have to match the level of coverage for medical.

The same number of employees and 50 percent of dependents covered by the medical plan must participate in the dental plan. The number of

Eligibility

Participants in the dental plan must meet or exceed the number in the medical plan, but it does not have to include the same employees.

EXAMPLE: There are 25 total employees, and 22 of them enroll in the medical plan. In this case, 22 employees also need to enroll in the dental plan. If 14 dependents enroll in the medical plan, then seven dependents must enroll in the dental plan.

Vision Plan

The public entity is required to maintain medical participation requirements to offer the vision plan. As with the dental plan, a subscriber and his or her dependents may enroll in vision even if the subscriber waives medical coverage. The subscriber must enroll in vision for his or her dependents to participate. The subscriber's level of coverage for vision does not have to match the level of coverage for medical.

The vision plan has no participation requirements.

Strive Employee Life & Family (SELF) program is available to eligible employees and members of their household 24 hours a day, every day of the year. The SELF program offers the following at no cost to you:

- Local, Private, In-Person Counseling for every day issues like stress, substance use, grief and loss. Get up to six (6) counseling sessions per problem, per person, per year;
- FinancialConnect® to assist with a wide range of money issues, such as retirement planning and saving for college;
- LegalConnect® to talk on the phone with an attorney for legal help, ask questions and plan next steps;
- IDResources® to talk to on the phone with an identity theft or fraud resolution specialist;
- FamilySource® call or go online to get expert help with every day issues, such as child and elder care, moving and relocation and vacation planning;
- GuidanceResources® is an online library of resources for health, wellness, consumer, family, career, education and more;

You and members of your household can keep using the SELF program for 18 months following your retirement and through the month after you are laid off. Your household members can use the SELF program for six (6) months after your death. Detailed information about the SELF program can be found on our MCHCP website at mchcp.org.

The SELF program is paid by the employer and requires 100 percent participation of employees eligible for medical coverage and can be expanded to additional classifications. This includes employees who waive other coverage.

This is the only benefit in which an employee may have dual coverage.

EXAMPLE: Bob and Sue are married. They each work for an entity covered by MCHCP offering the SELF program. Bob and Sue are each eligible to use the SELF program's benefits under both employer plans.

Contribution Levels

Medical Plan

Active employees and elected/appointed officials

- The public entity must contribute at least 50 percent toward the lowest-cost employee-only monthly premium for each participating employee
- If elected/appointed officials are eligible to participate, this minimum contribution applies to them as well

Retirees

- No contribution requirement for retirees

Dependents

- No contribution requirement for dependents. Dependents are eligible for all plans, as long as the employee is enrolled

Dental Plan

The employer must contribute at least 50 percent toward the employee-only monthly premium

Vision Plan

No employer contribution is required toward the monthly premium

Strive Employee Life & Family (SELF) program The employer must contribute 100 percent of the monthly premium

Eligibility

Eligibility Changes

A public entity may change its eligibility requirements during any of the following:

- During the annual Open Enrollment period. The public entity must submit the *Selection of Offerings* form stating the new policy. The policy will go into effect Jan. 1 of the following year
- Thirty (30) days prior to the end of its fiscal year. The public entity's top administrator must write a letter requesting the change
- A new employee classification is added to the public entity. The determination of this employee classification for eligibility is at the discretion of the public entity

Waiting/Probationary Periods

A waiting/probationary period is the length of time the employer requires an employee to be employed before he or she is eligible for health insurance coverage. Public entities may set different waiting/probationary periods for different employee classifications (for example, full-time vs. part-time).

EXAMPLE: John begins employment with the public entity on January 25. John has a 90-day waiting period. John becomes eligible to enroll in MCHCP coverage on April 25. John's 31-day eligibility period to enroll in MCHCP coverage begins on April 25.

Termination Policy

Chapter 103 of the Revised Statutes of Missouri allows MCHCP to terminate an entity for any of the following reasons:

- Failure to pay premiums in a timely manner
- Failure to abide by the terms and conditions of the Participation Agreement
- Failure to maintain participation requirements
- Failure to abide by the applicable provisions of Chapter 103 or rules and regulations promulgated by MCHCP
- Insufficient funding is received by MCHCP to continue the plan

A public entity may terminate voluntarily with 90 days written notice prior to the end of the contract period.

Enrollment

New Employees

Employees eligible for coverage must submit a completed enrollment form to MCHCP for coverage within 31 days of the eligibility date. If the enrollment form is received before the eligibility date, coverage may begin on that date or the first of the following month.

The employee and the Human Resources Officer signatures are required on the *Enroll/Change/Cancel/Waive form*. Employees who fail to enroll during the 31-day period may enroll during the next Open Enrollment for coverage to begin the following January.

EXAMPLE: Jane begins employment with the public entity on January 25 and the pay rep submits the *Enroll/Change/Cancel/Waive form* to MCHCP by the end of January. Jane's coverage becomes effective February 1.

Waiving Coverage

If an employee is eligible for coverage but decides not to enroll, you must notify MCHCP. To help MCHCP keep accurate records and ensure eligible employees are notified of their rights during Open Enrollment, MCHCP must have a signed *Enroll/Change/Cancel/Waive form* on file for each eligible employee.

Dual Coverage

Employees eligible for MCHCP coverage through two different public entities must elect coverage through one of the employers. Employees cannot have dual coverage for medical, dental or vision benefits through MCHCP. Members may have coverage under both employers with MCHCP's Strive Employee Life & Family (SELF) program.

EXAMPLE: An employee works for both Public Entity A and Public Entity B. Both entities offer MCHCP products. The employee is required to select the entity through which he or she wants to enroll.

Spouses employed by the same public entity may elect coverage either as an individual or as

employee/spouse (if allowed by the employer), but not both.

EXAMPLE: An employee works for Public Entity A, which offers MCHCP products. His or her spouse works for Public Entity B, which also offers MCHCP products. The employee is required to select one entity through which he or she wants to enroll. The employee cannot be covered as both an employee and a dependent.

If a public entity employee covered by MCHCP is married to a Missouri state employee covered by MCHCP, one employee may cover the other, or they may enroll separately under their individual employers.

EXAMPLE: John is a public entity employee, and his wife, Jane, works for the state of Missouri. Both employers offer MCHCP benefits. Jane waives her coverage and enrolls under John's plan.

The employee who covers the dependent children on the medical insurance must also cover the children on dental and vision, if elected.

EXAMPLE: Jane enrolls herself and their children on her medical plan. John's public entity offers dental, but since the children are on Jane's medical plan, John cannot enroll the children in his dental. The couple can change their elections during Open Enrollment. If John is a new hire at a public entity, Jane may cancel the medical coverage on the children for John to enroll them during his initial enrollment period for both the medical and dental coverage.

Transfers

When a public entity employee transfers to state employment, his or her effective date is the first of the month coinciding with or after the date enrollment information is received by MCHCP.

If a state retiree currently covered by MCHCP becomes eligible for coverage under a public entity employer, they have the option to enroll as an active employee. If active employment ends, the employee may choose to continue coverage as a public entity retiree or revert back to their state retiree coverage, as long as MCHCP coverage is continuous. The public entity employee may only revert back to the original state coverage (medical, dental and/or vision) elected at the time of their state retirement.

Enrollment

Terminations

Health insurance coverage ends on the **last day of the month** in which the subscriber's employment terminates, regardless of whether the subscriber voluntarily resigns or is terminated by the employer. This includes employees who remain employed by the public entity, but in a classification that is no longer eligible for coverage. MCHCP sends a COBRA notification to continue health insurance to all eligible members listed on the termination form.

If employment terminates or is no longer eligible for coverage, the subscriber's signature is **not** required on the *Enroll/Change/Cancel/Waive* form. The HR/payroll representative **must** sign the form.

Due to COBRA requirements, HR/payroll representatives **must** notify MCHCP of a termination as soon as possible. Termination forms received more than 60 days after a subscriber's termination are **not** retro-terminated, and premiums are **not reimbursed** for more than 60 days prior to the date the form is received in our office.

EXAMPLE: Patrick is terminated from Public Entity A on Aug. 6. MCHCP receives the termination form on Nov. 15. The effective date for Patrick's termination of coverage is Sept. 30 because the form was not received until November. If MCHCP had received Patrick's termination form in August, the termination would have been effective Aug. 31.

Open Enrollment

Open Enrollment is the annual period when public entities may modify the plans offered, and active employees may modify plan selections. During this time, an active employee may enroll in medical, dental and/or vision plans, and add or cancel dependent coverage if offered by the public entity.

Retirees may not add dependents during Open Enrollment, but they may change plans. If the employer offers products, such as dental or vision coverage, for the first time, retirees can enroll

during Open Enrollment for the first year they are eligible.

If the retiree fails to enroll, he or she may not enroll in the product(s) at a later date.

Any changes made during Open Enrollment go into effect January 1 of the following year. Public entities receive Open Enrollment information each August. Use the *Selection of Offerings* form to choose coverage for the upcoming year and provide information about eligible employees, classification of employees, waiting/probationary periods and primary contacts.

Notifying MCHCP of Changes

Any time an employee needs to make changes, the employee and human resources/payroll representative must complete the *Enroll/Change/Cancel/Waive* form and submit it to MCHCP immediately by fax, mail or uploading it online through your myMCHCP account. If you fax the form, be sure to print a confirmation sheet for your records.

Consolidated Omnibus Budget

Reconciliation Act (COBRA)

Individuals entitled to COBRA continuation coverage are called principal qualified beneficiaries. COBRA requires MCHCP to offer principal qualified beneficiaries and covered dependents the opportunity for temporary extension of health coverage. Continuation coverage is offered at group rates plus 2 percent when coverage under the plan would otherwise end due to certain qualifying events, and will go into effect the first of the month after the qualifying event. Premiums must be paid for coverage from that date forward, even if the election is made after that date. Qualifying events include, but are not limited to:

Enrollment

- Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment
- Death of a subscriber
- Divorce or legal separation
- Subscriber becomes entitled to Medicare
- Child turns 26 - When a dependent child turns 26, the participant-only premium applies, not the child-only premium. The child-only premium applies when an employee terminates employment and continues coverage on his or her child(ren) through COBRA.

Upon initial enrollment, MCHCP sends a letter to notify members of their COBRA rights. Once MCHCP is notified that a qualifying event has occurred, MCHCP notifies covered individuals of their rights to elect continuation coverage. Each qualified beneficiary has independent election rights and has 60 days from either the date the coverage is lost under MCHCP or from the date notification was provided by MCHCP of the qualifying event, whichever date is later.

The COBRA enrollment form requires the date COBRA coverage is effective and the reason COBRA coverage is being elected. This information determines the length of continuation coverage.

Certificates of Coverage

Under HIPAA regulations, health insurance plans are required to issue Certificates of Coverage for previous health insurance coverage. MCHCP sends a Certificate of Coverage and information concerning the COBRA qualifications to any person terminating coverage.

Billing

Payment and Refund of Premium

Bills are produced on approximately the 15th of each month and represent member data received and processed into our system prior to that date. A premium received in our office by the 15th of the month is posted to the entity account and is advanced to the health plans associated with the billing.

To ensure the billing process runs smoothly:

- Send in forms when employees make changes to their coverage. The MCHCP billing system will adjust the entity's billing when forms are received in our office. Sending forms in a timely manner ensures changes appear on the billing statement before paying MCHCP
- Send all forms to MCHCP as soon as they are completed by the employee and signed by the human resource/payroll representative. Completion of enrollment or termination forms ensures timely processing of data between MCHCP and the health care plans

Premiums billed for the current month must be remitted to MCHCP on or before the 15th of each month. Past-due premiums are reflected on the entity's billing and must be reported to the health care plans as shortages. Delinquent premium may cause a lapse in coverage for employees or terminate coverage with MCHCP.

EXAMPLE: June coverage is billed on May 15 and is due to MCHCP by June 15.

Contact your Member Education Specialist immediately if you have questions about billing. This gives the specialist the opportunity to research your billing question and provide a timely response.

Making adjustments to payment before forms are received by MCHCP can make reconciling your statements very difficult.

Understanding Your Bill

The following codes may appear on your bill:

AEO	Active Employee Only
AEC	Active Employee with Child(ren)
EREO	Early Retiree Employee Only
EREC	Early Retiree Employee with Child(ren)
ERES65	Early Retiree Employee with Spouse>=65
REO	Retiree Employee Only
REC	Retiree with Child(ren)
AES	Active Employee with Spouse
AEF	Active Employee with Family
ERES	Early Retiree Employee with Spouse
EREF	Early Retiree Employee with Family
EREF65	Early Retiree Employee with Family>=65
RES	Retiree with Spouse
REF	Retiree with Family

The first four digits of the account number are assigned to the entity as a whole.

EXAMPLE: 1234 is the City Housing Authority. The fifth digit indicates the member category. 12341 is the "one account" and is the active employee account for the City Housing Authority.

2	Active Employee Only
3	Retirees – with Medicare, direct billed
5	Retirees – non–Medicare, direct billed
7	Retirees – with Medicare, billed through PE
9	Retirees – non–Medicare, billed through PE
6	COBRA participant

Billing

ACH Payment Option

An entity may choose to pay by paper check or electronically. If you choose the electronic option, you must fill out an *Authorization Agreement for Direct Deposits (ACH Credits)* form. You can request a copy from your Member Education Specialist. This agreement allows you to deposit your monthly balance into MCHCP's checking account. You must initiate the payment each month. It is recommended that you do this by the 12th of each month so that payment can be received and processed by the 15th.

Delinquent Account Policy

A premium received after the 15th of the month is delinquent and cannot be processed and remitted to the health care plans in a timely manner. Failure to remit the premium to the health care plans results in breaks or losses of coverage for employees. Delayed premium remittance also affects the administrative costs passed on to MCHCP by our health care plans. These costs affect all members of our public entity pool.

If premium is not received by the due date, the public entity is notified. Failure to bring the account into current status will result in termination of the entity's coverage retroactive to the last full month of paid coverage.

EXAMPLE: April premium is not received by April 15. The entity is notified of the past-due amount. If no payment is received after the notice of delinquency, the entity is terminated effective March 31, the last full month for which premium was received.

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