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 members are different and have unique needs. To meet your unique needs, MCHCP offers a variety of options when it comes to health care benefits.

The 2020 MCHCP Benefit Guide will help active state employees and non-Medicare retiree members understand their benefits and make informed decisions. This booklet outlines the plan options available, and explains how each one works.
# Medical & Pharmacy Plan Overview (for State Employees and Non-Medicare Retiree Members)

<table>
<thead>
<tr>
<th></th>
<th>Health Savings Account (HSA) Plan</th>
<th>PPO 750 Plan</th>
<th>PPO 1250 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
<td>Network</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$1,650/individual $3,300/family</td>
<td>$3,300/individual $6,600/family</td>
<td>$750/individual $1,500/family</td>
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<td><strong>Medical Out-of-Pocket Maximum</strong></td>
<td>$4,950/individual $9,900/family</td>
<td>$9,900/individual $19,800/family</td>
<td>$2,250/individual $4,500/family</td>
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<tr>
<td><strong>Prescription Out-of-Pocket Maximum</strong></td>
<td>Combined with Medical</td>
<td>$4,150/individual $8,300/family</td>
<td>No Maximum</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>MCHCP pays 100% 40% coinsurance</td>
<td>MCHCP pays 100% 40% coinsurance</td>
<td>MCHCP pays 100% 40% coinsurance</td>
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<td><strong>Office Visit</strong></td>
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<td>20% coinsurance 40% coinsurance</td>
<td>20% coinsurance 40% coinsurance</td>
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<tr>
<td><strong>Urgent Care</strong></td>
<td>20% coinsurance</td>
<td>Network Benefit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>20% coinsurance</td>
<td>Network Benefit</td>
<td>$250 copayment plus 20% coinsurance</td>
</tr>
<tr>
<td><strong>Hospital (Inpatient)</strong></td>
<td>20% coinsurance 40% coinsurance</td>
<td>$200 copayment plus 40% coinsurance</td>
<td>$200 copayment plus 40% coinsurance</td>
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<td><strong>Lab and X-ray</strong></td>
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<td>20% coinsurance 40% coinsurance</td>
<td>20% coinsurance 40% coinsurance</td>
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<tr>
<td><strong>Surgery</strong></td>
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<td>20% coinsurance 40% coinsurance</td>
<td>20% coinsurance 40% coinsurance</td>
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<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Generic: 10% coinsurance up to $50* Preferred: 20% coinsurance up to $100* Non-Preferred: 40% coinsurance up to $200*</td>
<td>Generic and Preferred: 40% coinsurance Non-Preferred: 50% coinsurance</td>
<td></td>
</tr>
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<td><strong>Days' Supply</strong></td>
<td>1-31 days 32-60 days 61-90 days (home delivery) 61-90 days (retail)</td>
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<td></td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>$10 $20 $25 $30 $40 $80 $100 $120 $200 $250 $300</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preferred</strong></td>
<td>$40</td>
<td>$80</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Non-Preferred</strong></td>
<td>$100</td>
<td>$200</td>
<td>$250</td>
</tr>
</tbody>
</table>

*These amounts are for a 31-day supply.

Specialty

- Primary Care or Mental Health: $25 copayment
- Specialist: $40 copayment
- Chiropractor: $20 copayment or 50% of total cost of service, whichever is less

- Network Benefit

Reduced costs for certain diabetic drugs and supplies.
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 750, and the PPO 1250 – offer the same benefits, such as:

- 100% coverage of preventive care – such as preventive exams, vaccinations, age-specific screenings and much more – when using a network provider.
- Your choice of health care providers, pharmacies and hospitals from a nationwide network, usually at a lower cost to you.

While the benefits are the same in all three medical plans, premium, deductible and out-of-pocket (OOP) costs vary. 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.

MCHCP offers a benefit plan option to exclude coverage for contraception if these items or procedures are contrary to your religious beliefs or moral convictions. You must complete the Non-Contraception Benefit Option form to select this option.

**Introducing Anthem as MCHCP Medical Plan Administrator**

Starting Jan. 1, 2020, Anthem will be MCHCP’s medical plan administrator for active state employees and non-Medicare retiree members. The HSA, PPO 1250 and PPO 750 plans are still the available plan options, but you will have access to providers through the Anthem networks. Anthem offers a brand new feature called Total Health Total You including an app you can download, virtual health care visits, and much more. For more information, please read Anthem’s Welcome Booklet that introduces MCHCP members to the services and assistance that will be available.
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 100%, they must be supplied by a network provider, billed as routine, without indication of an injury or illness, and meet preventive service guidelines.

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 includes, but is not limited to:

**Adult**
- Alcohol Misuse, Screening and Behavioral Counseling
- Colorectal Cancer, Screening
- Depression, Screening
- Diabetes Mellitus, Screening
- Hepatitis C Virus Infection, Screening
- Vaccinations
- Lung Cancer, Screening
- Obesity, Screening
- Preventive Exam, and other services ordered as part of the exam
- Routine lab services
- Skin Cancer, Counseling
- Tobacco Use, Counseling and Interventions
- Tuberculosis, Screening
Men
• Abdominal Aortic Aneurysm, Screening

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

Children
• Child Exam – including depression, obesity, hearing and vision screenings and immunizations
• Depression in Adolescents, Screening

Naturally Slim®
Eligible members enrolled in an MCHCP medical plan can take advantage of a weight management and disease prevention program called Naturally Slim. Naturally Slim is a simple online program that teaches you how to lose weight and improve your health while eating the foods you love. It is covered as a preventive service, so that means no cost to the member! MCHCP non-Medicare and non-TRICARE plan members aged 18 and older, who meet certain criteria are eligible to learn how to eat to reduce chances of getting a serious disease like diabetes or heart disease and increase an opportunity to live a longer, healthier life.

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

The Health Savings Account (HSA) Plan is a qualified high-deductible plan. You will have a lower or no-cost premium with this plan, when compared to other MCHCP medical plans.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Services</strong></td>
<td>MCHCP pays 100%</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$1,650 Individual $3,300 Family</td>
<td>$3,300 Individual $6,600 Family</td>
</tr>
<tr>
<td><strong>Medical OOP Max</strong></td>
<td>$4,950 Individual $9,900 Family</td>
<td>$9,900 Individual $19,800 Family</td>
</tr>
<tr>
<td><strong>Prescription OOP Max</strong></td>
<td>Combined with Medical</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Services</strong></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>20% coinsurance</td>
<td>Network Benefit</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>20% coinsurance</td>
<td>Network Benefit</td>
</tr>
</tbody>
</table>
How the HSA Plan Works

1. Active employee opens an HSA through Central Bank in Jefferson City. 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 9). Active employees may contribute through voluntary payroll deductions. Retirees may contribute by making deposits directly.

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 HSA funds. No claim forms are required.

5. There are no copayments with the HSA Plan. Members will pay all of their medical and prescription expenses, 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% of covered services and prescriptions. See Family Coverage section on page 9.

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.
- **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 three ways to save on taxes 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.
2020 HSA Annual Contribution Limits

<table>
<thead>
<tr>
<th>Contributions</th>
<th>Subscriber Only</th>
<th>Subscriber/Spouse</th>
<th>Subscriber/Child(ren)</th>
<th>Subscriber/Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRS Contribution Limit</td>
<td>$3,550</td>
<td></td>
<td></td>
<td>$7,100</td>
</tr>
<tr>
<td>IRS Contribution Limit (age 55 and older)</td>
<td>$4,550</td>
<td></td>
<td></td>
<td>$8,100</td>
</tr>
<tr>
<td>MCHCP Contribution (active employee subscribers only)</td>
<td>$300</td>
<td></td>
<td></td>
<td>$600</td>
</tr>
<tr>
<td>Active subscribers may contribute</td>
<td>$3,250</td>
<td></td>
<td></td>
<td>$6,500</td>
</tr>
<tr>
<td>Active subscribers may contribute (age 55 and older)</td>
<td>$4,250</td>
<td></td>
<td></td>
<td>$7,500</td>
</tr>
</tbody>
</table>

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 meet only one (1) family deductible and out-of-pocket maximum if both are enrolled in the HSA Plan. For example, one spouse covers themselves and their children, while the other spouse covers only themselves. In this example, 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). The two married state employees must choose this option when enrolling.
Diabetes Self-Management Training/Education

Diabetes self-management training/education has 100% coverage after deductible is met for four visits, when taught by a Certified Diabetes Educator through a medical network provider. The education services must be ordered by a provider. Additional visits may be covered with 20% coinsurance.

Nutrition Counseling

Members enrolled in the HSA Plan who qualify may receive up to six sessions covered at 100% annually with a licensed health care professional (e.g., a registered dietitian) who is in the network or who practices at a network facility without preauthorization, after the deductible is met.

Virtual Visits through LiveHealth Online

Anthem offers virtual health care visits through LiveHealth Online. Using a smartphone, tablet or computer, MCHCP members can visit with a health care provider to assess symptoms, provide a treatment plan and even send a prescription to a local pharmacy for conditions ranging from pinkeye to stress and anxiety. An office visit cost will apply when using LiveHealth Online. For more information, please read Anthem’s Welcome Booklet.

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 Part A to contribute to the HSA.
  - A member may be enrolled in another qualified high deductible health plan, dental and/or vision plan.
- 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 information starting on page 18 for prescription drug coverage and coinsurance.
Transitioning from a Flexible Spending Account (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.

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31</td>
<td>FSA must have a zero balance in order to receive the MCHCP HSA contribution in January.</td>
</tr>
<tr>
<td>January</td>
<td>MCHCP contribution will be deposited into HSA if FSA has a zero balance on December 31.</td>
</tr>
<tr>
<td>March 15</td>
<td>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.</td>
</tr>
<tr>
<td>April</td>
<td>MCHCP contribution will be deposited into HSA if there were remaining FSA funds on December 31.</td>
</tr>
<tr>
<td>April 15</td>
<td>Deadline to submit claims for remaining FSA funds. Funds that are not claimed by this date will be forfeited.</td>
</tr>
</tbody>
</table>
**Overview**
You will have a higher premium with the PPO 750 plan, when compared to other MCHCP medical plans.

<table>
<thead>
<tr>
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<th>Network</th>
<th>Non-Network</th>
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</thead>
<tbody>
<tr>
<td><strong>Preventive Services</strong></td>
<td>MCHCP pays 100%</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$750 Individual $1,500 Family</td>
<td>$1,500 Individual $3,000 Family</td>
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<tr>
<td><strong>Medical OOP Max</strong></td>
<td>$2,250 Individual $4,500 Family</td>
<td>$4,500 Individual $9,000 Family</td>
</tr>
<tr>
<td><strong>Prescription OOP Max</strong></td>
<td>$4,150 Individual $8,300 Family</td>
<td>No Maximum</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>20% coinsurance</td>
<td>Network Benefit</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$250 copayment plus 20% coinsurance</td>
<td>Network Benefit</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>$200 copayment plus 20% coinsurance</td>
<td>$200 copayment plus 40% coinsurance</td>
</tr>
<tr>
<td><strong>Other Medical Services</strong></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>
How the PPO 750 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 $250 copayment (see Copayments section above).

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% 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 Missouri State Employee’s Cafeteria Plan (MOCafe) (if eligible).

Copayments

Members may pay a copayment for emergency room services, in addition to deductible or coinsurance. 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 Emergency Room service. Members also have a $200 copayment for inpatient services in addition to their deductible and coinsurance.

Copayments apply to the out-of-pocket maximum, but not the deductible.

See information starting on page 18 for 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, the medical plan begins paying claims for the individual. If one or more additional family members meet the individual deductible, the medical plan begins paying claims for the entire family.

Two married active state employees who cover children may meet only one (1) family deductible and out-of-pocket maximum if both are enrolled in the PPO 750. For example, one spouse covers themselves and their children, while the other spouse covers only themselves. In this example, this family would only have to meet one family deductible ($1,500), instead of a family deductible ($1,500) plus a separate individual deductible ($750). The two married state employees must choose this option when enrolling.
Diabetes Self-Management Training/Education

Diabetes self-management training/education has 100% coverage for four visits, when taught by a Certified Diabetes Educator through a medical network provider. The education services must be ordered by a provider. Additional visits may be covered with deductible and 20% coinsurance applying.

Nutrition Counseling

Members enrolled in the PPO 750 Plan who qualify may receive up to six sessions covered at 100% annually with a licensed health care professional (e.g., a registered dietitian) who is in the network or who practices at a network facility without preauthorization.

Virtual Visits through LiveHealth Online

Anthem offers virtual health care visits through LiveHealth Online. Using a smartphone, tablet or computer, MCHCP members can visit with a health care provider to assess symptoms, provide a treatment plan and even send a prescription to a local pharmacy for conditions ranging from pinkeye to stress and anxiety. An office visit cost will apply when using LiveHealth Online. For more information, please read Anthem’s Welcome Booklet.

Flexible Spending Account

The state of Missouri offers Flexible Spending Accounts (FSA) for members who are employed, administered by ASI Flex, that you can use to save money on premiums and qualified medical expenses.

Members automatically participate in Premium Only Participation, which allows premiums to be deducted pre-tax. You must opt out of Premium Only Participation if you do not want to participate.

Members covered by a PPO plan may participate in the Health Care FSA and members covered by the HSA Plan may participate in the Dental/Vision FSA. Both allow pre-tax money to be used to pay for certain medical expenses.

Visit www.mocafe.com, or contact ASI Flex at (800) 659-3035 or asi@asiflex.com for more information.
You will have a moderately-priced premium with the PPO 1250 plan, when compared to other MCHCP medical plans.

<table>
<thead>
<tr>
<th>Service</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>MCHCP pays 100%</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Deductible</td>
<td>$1,250 Individual</td>
<td>$2,500 Individual</td>
</tr>
<tr>
<td></td>
<td>$2,500 Family</td>
<td>$5,000 Family</td>
</tr>
<tr>
<td>Medical OOP Max</td>
<td>$3,750 Individual</td>
<td>$7,500 Individual</td>
</tr>
<tr>
<td></td>
<td>$7,500 Family</td>
<td>$15,000 Family</td>
</tr>
<tr>
<td>Prescription OOP Max</td>
<td>$4,150 Individual</td>
<td>No Maximum</td>
</tr>
<tr>
<td></td>
<td>$8,300 Family</td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td><strong>Primary Care or Mental Health:</strong> $25 copayment</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Chiropractor:</strong> $20 copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Specialist:</strong> $40 copayment</td>
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</tr>
<tr>
<td>Urgent Care</td>
<td>$50 copayment</td>
<td>Network Benefit</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$250 copayment plus</td>
<td>Network Benefit</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$200 copayment plus</td>
<td>$200 copayment plus</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Other Medical Services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>
Copayments
Members will pay a copayment for office visits and urgent care. Members may pay a copayment for Emergency Room services in addition to deductible and coinsurance. The Emergency Room 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 Emergency Room service. Members also have a $200 copayment for inpatient services in addition to deductible and coinsurance.

Copayments apply to the out-of-pocket maximum, but not the deductible.

How the PPO 1250 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. 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.
3. Chiropractor copayment may be less than $20 if it is more than 50 percent of the total cost of the service.
4. 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% of covered services (see Family Coverage section below).
5. 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 Missouri State Employee’s Cafeteria Plan (MOCafe) (if eligible).

See information starting on page 18 for 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, the medical plan begins paying claims for the individual. If one or more additional family members meet the individual deductible, the medical plan begins paying claims for the entire family.

Two married active state employees who cover children may meet only one (1) family deductible and out-of-pocket maximum if both are enrolled in the PPO 1250. For example, one spouse covers themselves and their children, while the other spouse covers only themselves. In this example, this family would only have to meet one family deductible ($2,500), instead of a family deductible ($2,500) plus a separate individual deductible ($1,250). The two married state employees must choose this option when enrolling.
Diabetes Self-Management Training/Education
Diabetes self-management training/education has 100% coverage for four visits, when taught by a Certified Diabetes Educator through a medical network provider. The education services must be ordered by a provider. Additional visits may be covered with deductible and applying 20% coinsurance.

Nutrition Counseling
Members enrolled in the PPO 1250 Plan who qualify may receive up to six sessions covered at 100% annually with a licensed health care professional (e.g., a registered dietitian) who is in the network or who practices at a network facility without preauthorization.

Virtual Visits through LiveHealth Online
Anthem offers virtual health care visits through LiveHealth Online. Using a smartphone, tablet or computer, MCHCP members can visit with a health care provider to assess symptoms, provide a treatment plan and even send a prescription to a local pharmacy for conditions ranging from pinkeye to stress and anxiety. An office visit cost will apply when using LiveHealth Online. For more information, please read Anthem’s Welcome Booklet.
Members automatically receive prescription drug 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 ESI. ESI places covered drugs into four levels: preferred generic, preferred brand, specialty and 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 generic or preferred brand 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.

If you are in the PPO 750 or PPO 1250 plan and your prescription allows for generic substitution, but you choose a brand name drug, you will pay the generic copayment and the cost difference between the brand-name and generic drug. The difference does not apply to the prescription out-of-pocket maximum.

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.
<table>
<thead>
<tr>
<th>Description</th>
<th>HSA Plan</th>
<th>PPO Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail — Network (Up to 31-day supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>10% coinsurance up to $50</td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Preferred</td>
<td>20% coinsurance up to $100</td>
<td>$40 copayment</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>40% coinsurance up to $200</td>
<td>$100 copayment</td>
</tr>
<tr>
<td><strong>Retail — Network (32- to 60-day supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>10% coinsurance up to $100</td>
<td>$20 copayment</td>
</tr>
<tr>
<td>Preferred</td>
<td>20% coinsurance up to $200</td>
<td>$80 copayment</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>40% coinsurance up to $400</td>
<td>$200 copayment</td>
</tr>
<tr>
<td><strong>Retail — Network (61- to 90-day supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>10% coinsurance up to $150</td>
<td>$30 copayment</td>
</tr>
<tr>
<td>Preferred</td>
<td>20% coinsurance up to $300</td>
<td>$120 copayment</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>40% coinsurance up to $600</td>
<td>$300 copayment</td>
</tr>
<tr>
<td><strong>Home Delivery — Network (61- to 90-day supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>10% coinsurance up to $150</td>
<td>$25 copayment</td>
</tr>
<tr>
<td>Preferred</td>
<td>20% coinsurance up to $300</td>
<td>$100 copayment</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>40% coinsurance up to $600</td>
<td>$250 copayment</td>
</tr>
<tr>
<td><strong>Retail — Non-Network (Up to 31-day supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>40% coinsurance</td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Preferred</td>
<td>40% coinsurance</td>
<td>$40 copayment</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>50% coinsurance</td>
<td>$100 copayment</td>
</tr>
<tr>
<td></td>
<td>Pay full price of prescription and file claim. Members are reimbursed the network discounted amount, less the applicable copayment or coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 31-day supply</td>
<td>Refer to cost savings amounts listed above.</td>
<td>$75 through Accredo</td>
</tr>
</tbody>
</table>
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 for those enrolled in a PPO Plan.

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.

Brand-for-Generic Substitution Program
The plan will prefer select brand drugs, as decided by ESI, and not cover their higher net-cost generic equivalent. Members will pay the generic copayment for the brand in this program.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. See page 22-23 for more details.
100 Percent Coverage
There are certain medications that MCHCP will cover at 100%, when accompanied by a prescription and filled at a network pharmacy:

- Aspirin, 81mg for women up to age 55 with preeclampsia risk, generic
- Aspirin, for adults 50-59 years of age for the prevention of cardiovascular disease and colorectal cancer, generic
- Birth control, preferred (non-preferred may be covered in limited situations)
- Bowel prep (preferred and OTC), generic
- Fluoride for children aged 6 months through 12 years
- Folic Acid, 400 to 800 mcg/day for women up to age 50, generic
- Iron Supplement for members aged 6 months through 12 months
- Nicotine replacement therapy, Over-the-Counter (OTC)
- Quit tobacco medications for members aged 18 and over, Preferred
- Statins for adults 40-75 years of age for the prevention of cardiovascular disease, generic low-to-moderate dose, when certain medical criteria are met
- Tamoxifen (generic), Raloxifene (generic) and brand Soltamox (Tamoxifen liquid for patients who have difficulty swallowing Tamoxifen tablets) for the prevention of breast cancer
- Vaccinations recommended by the Advisory Committee for Immunizations Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

Diabetes Support Services
Members needing diabetic medications or supplies can receive the following:

- Lower prescription copayments/coinsurance (see chart on page 22)
- Preferred glucometer (one per year), and prescribed preferred test strips and lancets covered at 100% for PPO members or 100% after deductible is met for HSA Plan members, when received through a network pharmacy.
HSA Plan Coinsurance for Diabetic Medications

<table>
<thead>
<tr>
<th>Network</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>5% coinsurance</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>up to $25</td>
<td>up to $50</td>
<td>up to $100</td>
</tr>
<tr>
<td>Non-Network</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>25% coinsurance</td>
</tr>
</tbody>
</table>

PPO Plan Copayments for Diabetic Medications

<table>
<thead>
<tr>
<th>Supply</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 31-day</td>
<td>$5</td>
<td>$20</td>
<td>$50</td>
</tr>
<tr>
<td>Up to 60-day</td>
<td>$10</td>
<td>$40</td>
<td>$100</td>
</tr>
<tr>
<td>Up to 90-day</td>
<td>$12.50</td>
<td>$50</td>
<td>$125</td>
</tr>
<tr>
<td>(Home Delivery)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 90-day</td>
<td>$15</td>
<td>$60</td>
<td>$150</td>
</tr>
<tr>
<td>(Retail)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

If you are covered by a PPO plan and your prescription allows for generic substitution, but you choose a brand-name drug, you will pay the generic copayment and the cost difference between the brand-name and generic drug. The difference does not apply to the prescription out-of-pocket maximum.

If ESI determines you are misutilizing drugs, you may be required to fill those drugs at only one pharmacy, and you'll be referred to case management for help.

More information about prescription drug coverage can be found on our website at www.mchcp.org.
How the 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 20 for more information.
   c. Specialty medications must be filled through Accredo, ESI’s home delivery, specialty pharmacy provider (see Specialty Medications section on page 20 for more information).

3. Pay for prescription. Drug costs are based on the drug tier (generic or preferred brand, specialty, or non-preferred) and where the prescription was filled (retail pharmacy or home delivery). PPO Plan members pay a copayment. HSA Plan members pay the full discounted cost of the prescription until the deductible is met. After that, HSA members pay coinsurance up to a maximum amount (see chart on page 19 for more information).
   a. Some prescriptions are covered at 100% (see section on page 21 for more information).

4. Members will continue to pay prescription copayments/coinsurance until their prescription 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.
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.
Overview
MetLife 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. MetLife offers members cost-control and claim-filing benefits.
   b. If utilizing a non-network provider, the provider may submit the claim directly to MetLife or request the member to submit a claim form to MetLife. The member may be responsible for any difference in the cost between the dentist’s fee and your plan’s benefit payment. 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 26 for more information).
3. Coverage is limited to $2,000 per person per calendar year.

* Non-network diagnostic and preventive is covered at 100% of the network negotiated fee. Non-network providers may balance bill you the difference.
The chart below provides a summary of the covered services at a network provider.

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

The cost of dental insurance is paid by the employee/retiree.

Visit the MCHCP website for more information.

Non-network providers may balance bill you the difference between Metlife’s payment and billed charge.
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 providers. 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.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams - once every calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two annual exams covered for children up to age 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Exam</td>
<td>$10 copayment</td>
<td>Reimbursed up to $45</td>
</tr>
<tr>
<td>Lenses - once every calendar year; copayment applies to all lens options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single-vision lenses (per pair)</td>
<td>$25 copayment</td>
<td>Reimbursed up to $30</td>
</tr>
<tr>
<td>Bifocal lenses (per pair)</td>
<td>$25 copayment</td>
<td>Reimbursed up to $50</td>
</tr>
<tr>
<td>Trifocal lenses (per pair)</td>
<td>$25 copayment</td>
<td>Reimbursed up to $65</td>
</tr>
<tr>
<td>Lenticular lenses (per pair)</td>
<td>$25 copayment</td>
<td>Reimbursed up to $100</td>
</tr>
<tr>
<td>Polycarbonate lenses (per pair)</td>
<td>100% coverage</td>
<td>Not covered</td>
</tr>
<tr>
<td>Applies to children up to age 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard anti-reflective coating</td>
<td>$30 copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Premium plan only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard progressive multifocal</td>
<td>$50 copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Premium plan only</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Benefits Network Non-Network

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frames — once every two calendar years; once every calendar year for children up to age 18</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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

<table>
<thead>
<tr>
<th>Frames</th>
</tr>
</thead>
</table>

| **Contact Lenses - once every calendar year in place of eye glass lenses** |

#### 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

<table>
<thead>
<tr>
<th>Elective</th>
<th>If member prefers contacts to glasses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail allowances may be used over multiple visits in the same calendar year.</td>
<td></td>
</tr>
</tbody>
</table>

26
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elective</strong>&lt;br&gt;If member prefers contacts to glasses&lt;br&gt;Retail allowances may be used over multiple visits in the same calendar year.</td>
<td><strong>Premium Plan</strong>&lt;br&gt;Up to $175 retail allowance and 15% discount off conventional or 10% discount off disposable remaining balance&lt;br&gt;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.</td>
<td>Contact lenses reimbursed up to $105</td>
</tr>
<tr>
<td><strong>Necessary</strong>&lt;br&gt;If medically necessary with prior approval from National Vision Administrators, L.L.C. (NVA)</td>
<td></td>
<td>Contact lenses reimbursed up to $210</td>
</tr>
<tr>
<td><strong>Fitting and Evaluation</strong></td>
<td>$20 copayment for daily contact lenses;&lt;br&gt;$30 copayment for extended contact lenses;&lt;br&gt;$50 copayment for specialty contact lenses</td>
<td>Reimbursed up to $20 for daily contact lenses;&lt;br&gt;$30 copayment for extended or specialty contact lenses</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>In Missouri, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.</td>
<td></td>
</tr>
<tr>
<td><strong>EyeEssential Discount Plan</strong></td>
<td>When members exhaust their annual benefits, NVA offers the EyeEssential Discount Plan, which provides significant discounts on materials through participating NVA network providers.</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### LASIK Discounts

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

**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 27-30 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 27-30 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. Household members can use the SELF program for six months after the employee’s 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®, 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. Eligible members can earn the incentives at any time throughout the year.

The Partnership Incentive
The Partnership Incentive of $25 per month is available to active employee subscribers and to non-Medicare retiree 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.

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, 2019, will begin receiving the Incentive on Jan. 1, 2020.

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 steps are completed.

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 1.) active employee subscribers and their covered spouses, and 2.) non-Medicare retiree subscribers and their covered non-Medicare spouses.

Qualifying members must be enrolled in an MCHCP medical plan, and not have the TRICARE Supplement Plan.

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. Members can download the Quit Tobacco Road Map through their myMCHCP account, or MCHCP will mail them one. The Quit Tobacco Road Map is a self-help guide with resources and tips to improve chances of quitting.

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, 2019, will begin receiving the Incentive on Jan. 1, 2020.

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% coverage for preferred quit tobacco medications and over-the-counter nicotine replacement therapy with a prescription.
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, and 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 provided in connection with the Strive for Wellness® Program that personally identifies you 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.
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, basic preventive care and behavioral health counseling services, 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 and shingles
- Health screenings
- Behavioral health counseling

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

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

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

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**Medical Plan**
Anthem
HSA Plan, PPO 750 and PPO 1250
www.anthem.com
844-516-0248
7 a.m. to 6 p.m. M-F

**Claims Address**
PO Box 105187
Atlanta, GA 30348-5187

**Appeals Address**
Appeals Resolution Team
PO Box 14463
Lexington, KY 40512

**Prescription Drug Plan for Non-Medicare Members**
Express Scripts, Inc. (ESI)
www.express-scripts.com
800-797-5754
TTY: 866-707-1862
24 hours a day

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

**Appeals Address**
Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63166-6588
fax: 877-852-4070

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

**Dental Plan**
Metlife
www.metlife.com/mybenefits
844-222-9106 dedicated to MCHCP
7 a.m. to 10 p.m. M-F

**Claims Address**
MetLife Dental Claims
PO Box 14588
Lexington, KY 40512

**Appeals Address**
MetLife Group Claims Review
PO Box 14589
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

**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: Clinical Services
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.
Room 478
Jefferson City, MO
573-526-3175
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’s nurse line.

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.
Important Notice from Missouri Consolidated Health Care Plan About Your Prescription Drug Coverage and Medicare*

Please read this notice carefully, and keep it where you can find it. This notice has information about your current prescription drug coverage with Missouri Consolidated Health Care Plan (MCHCP), and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. MCHCP has determined that the prescription drug coverage offered by MCHCP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare, and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current MCHCP coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

*This notice applies to Medicare-eligible members who are not enrolled in the Express Scripts Medicare Prescription Drug Plan (PDP) through MCHCPR
If you decide to join a Medicare drug plan and drop your current MCHCP coverage, you and your dependents may be able to get your MCHCP coverage back.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with MCHCP and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage…**

Contact MCHCP Member Services for further information at 800-487-0771. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MCHCP changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage…**

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
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, etc.)

- 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 Bev Barr.

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

Bev Barr
Compliance Specialist
832 Weathered Rock Court, PO Box 104355
Jefferson City, MO 65110
Phone: 800-487-0771
Fax: 866-346-8785
Compliance@mchcp.org
You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Bev Barr (Compliance Specialist) 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](http://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)
Every Member.
Every Moment.
Health Matters.