

SENATE SUBSTITUTE
FOR
SENATE COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 860

AN ACT

To repeal sections 191.671, 376.385, 376.429, 376.446, 376.452, 376.454, 376.779, 376.781, 376.782, 376.811, 376.845, 376.1199, 376.1200, 376.1209, 376.1210, 376.1215, 376.1218, 376.1219, 376.1220, 376.1224, 376.1225, 376.1230, 376.1232, 376.1235, 376.1250, 376.1253, 376.1257, 376.1275, 376.1290, 376.1550, and 376.1900, RSMo, and to enact in lieu thereof thirty-two new sections relating to short-term major medical insurance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI,
AS FOLLOWS:

1 Section A. Sections 191.671, 376.385, 376.429, 376.446,
2 376.452, 376.454, 376.779, 376.781, 376.782, 376.811, 376.845,
3 376.1199, 376.1200, 376.1209, 376.1210, 376.1215, 376.1218,
4 376.1219, 376.1220, 376.1224, 376.1225, 376.1230, 376.1232,
5 376.1235, 376.1250, 376.1253, 376.1257, 376.1275, 376.1290,
6 376.1550, and 376.1900, RSMo, are repealed and thirty-two new
7 sections enacted in lieu thereof, to be known as sections
8 191.671, 376.008, 376.385, 376.429, 376.446, 376.452, 376.454,
9 376.779, 376.781, 376.782, 376.811, 376.845, 376.1199, 376.1200,
10 376.1209, 376.1210, 376.1215, 376.1218, 376.1219, 376.1220,
11 376.1224, 376.1225, 376.1230, 376.1232, 376.1235, 376.1250,
12 376.1253, 376.1257, 376.1275, 376.1290, 376.1550, and 376.1900,
13 to read as follows:

1 191.671. 1. No other section of this act shall apply to
2 any insurer, health services corporation, or health maintenance
3 organization licensed by the department of insurance, financial
4 institutions and professional registration which conducts HIV
5 testing only for the purposes of assessing a person's fitness for
6 insurance coverage offered by such insurer, health services
7 corporation, or health maintenance corporation, except that
8 nothing in this section shall be construed to exempt any insurer,
9 health services corporation or health maintenance organization in
10 their capacity as employers from the provisions of section
11 191.665 relating to employment practices.

12 2. Upon renewal of any individual or group insurance
13 policy, subscriber contractor health maintenance organization
14 contract covering medical expenses, no insurer, health services
15 corporation or health maintenance organization shall deny or
16 alter coverage to any previously covered individual who has been
17 diagnosed as having HIV infection or any HIV-related condition
18 during the previous policy or contract period only because of
19 such diagnosis, nor shall any such insurer, health services
20 corporation or health maintenance organization exclude coverage
21 for treatment of such infection or condition with respect to any
22 such individual. The provisions of this subsection shall not
23 apply to short-term major medical policies with durations of less
24 than one year.

25 3. The director of the department of insurance, financial
26 institutions and professional registration shall establish by
27 regulation standards for the use of HIV testing by insurers,
28 health services corporations and health maintenance

1 organizations.

2 4. A laboratory certified by the U.S. Department of Health
3 and Human Services under the Clinical Laboratory Improvement Act
4 of 1967, permitting testing of specimens obtained in interstate
5 commerce, and which subjects itself to ongoing proficiency
6 testing by the College of American Pathologists, the American
7 Association of Bio Analysts, or an equivalent program approved by
8 the Centers for Disease Control shall be authorized to perform or
9 conduct HIV testing for an insurer, health services corporation
10 or health maintenance organization pursuant to this section.

11 5. The result or results of HIV testing of an applicant for
12 insurance coverage shall not be disclosed by an insurer, health
13 services corporation or health maintenance organization, except
14 as specifically authorized by such applicant in writing. Such
15 result or results shall, however, be disclosed to a physician
16 designated by the subject of the test. If there is no physician
17 designated, the insurer, health services corporation, or health
18 maintenance organization shall disclose the identity of
19 individuals residing in Missouri having a confirmed positive HIV
20 test result to the department of health and senior services.
21 Provided, further, that no such insurer, health services
22 corporation or health maintenance organization shall be liable
23 for violating any duty or right of confidentiality established by
24 law for disclosing such identity of individuals having a
25 confirmed positive HIV test result to the department of health
26 and senior services. Such disclosure shall be in a manner that
27 ensures confidentiality. Disclosure of test results in violation
28 of this section shall constitute a violation of sections 375.930

1 to 375.948 regulating trade practices in the business of
2 insurance. Nothing in this subsection shall be construed to
3 foreclose any remedies existing on June 1, 1988.

4 376.008. 1. All short-term major medical policies
5 delivered or issued for delivery in this state shall include on
6 any application for coverage and on the fact page of all policies
7 a conspicuous and clearly captioned paragraph stating:

8 "This policy may not cover preexisting conditions,
9 including conditions you may currently have and are
10 unaware of but are not diagnosed until the policy's
11 term. This policy may not cover certain essential
12 health benefits, including prescription drugs,
13 preventative care, and emergency services. Before you
14 realize benefits under this policy, you may be
15 responsible for a deductible and/or coinsurance. Be
16 sure to discuss these items with your insurance broker
17 before purchasing a short-term medical policy.".

18 2. No short-term major medical policy shall be delivered or
19 issued for delivery in this state until the prospective insured
20 has confirmed receipt of a benefit summary statement. As used in
21 this section, "benefit summary statement" shall mean a plain
22 language explanation of the following:

23 (1) Coverage limits, if any, expressed in dollars for:

24 (a) Each occurrence;

25 (b) Each covered benefit, including but not limited to any
26 benefit that is or was a covered benefit for any duration or
27 dollar amount during the contract period and anything included
28 under subdivision (2) of this subsection; and

1 (c) Each contract period;
2 (2) Copayments and deductibles for each covered benefit,
3 including but not limited to:
4 (a) Inpatient hospital care;
5 (b) Outpatient hospital care;
6 (c) Nonhospital inpatient care;
7 (d) Nonhospital outpatient care;
8 (e) Prescription drugs; and
9 (f) Emergency services; and
10 (3) Any copayment or deductible for an illness or
11 affliction which differs from the copayment or deductible
12 required to be described under subdivision (2) of this
13 subsection.

14 376.385. 1. Each entity offering individual and group
15 health insurance policies providing coverage on an
16 expense-incurred basis, individual and group service or indemnity
17 type contracts issued by a health services corporation,
18 individual and group service contracts issued by a health
19 maintenance organization, all self-insured group arrangements, to
20 the extent not preempted by federal law, and all managed health
21 care delivery entities of any type or description, that are
22 delivered, issued for delivery, continued or renewed in this
23 state on or after January 1, 1998, shall offer coverage for all
24 physician-prescribed medically appropriate and necessary
25 equipment, supplies and self-management training used in the
26 management and treatment of diabetes. Coverage shall include
27 persons with gestational, type I or type II diabetes.

28 2. Health care services required by this section shall not

1 be subject to any greater deductible or co-payment than any other
2 health care service provided by the policy, contract or plan.

3 3. No entity enumerated in subsection 1 of this section may
4 reduce or eliminate coverage due to the requirements of this
5 section.

6 4. Nothing in this section shall apply to short-term major
7 medical policies with durations of less than one year, or to
8 accident-only, specified disease, hospital indemnity, Medicare
9 supplement, long-term care, or other limited benefit health
10 insurance policies.

11 376.429. 1. All health benefit plans, as defined in
12 section 376.1350, that are delivered, issued for delivery,
13 continued or renewed on or after August 28, 2006, and providing
14 coverage to any resident of this state shall provide coverage for
15 routine patient care costs as defined in subsection 7 of this
16 section incurred as the result of phase II, III, or IV of a
17 clinical trial that is approved by an entity listed in subsection
18 4 of this section and is undertaken for the purposes of the
19 prevention, early detection, or treatment of cancer. Health
20 benefit plans may limit coverage for the routine patient care
21 costs of patients in phase II of a clinical trial to those
22 treating facilities within the health benefit plans' provider
23 network; except that, this provision shall not be construed as
24 relieving a health benefit plan of the sufficiency of network
25 requirements under state statute.

26 2. In the case of treatment under a clinical trial, the
27 treating facility and personnel must have the expertise and
28 training to provide the treatment and treat a sufficient volume

1 of patients. There must be equal to or superior,
2 noninvestigational treatment alternatives and the available
3 clinical or preclinical data must provide a reasonable
4 expectation that the treatment will be superior to the
5 noninvestigational alternatives.

6 3. Coverage required by this section shall include coverage
7 for routine patient care costs incurred for drugs and devices
8 that have been approved for sale by the Food and Drug
9 Administration (FDA), regardless of whether approved by the FDA
10 for use in treating the patient's particular condition, including
11 coverage for reasonable and medically necessary services needed
12 to administer the drug or use the device under evaluation in the
13 clinical trial.

14 4. Subsections 1 and 2 of this section requiring coverage
15 for routine patient care costs shall apply to phase III or IV of
16 clinical trials that are approved or funded by one of the
17 following entities:

18 (1) One of the National Institutes of Health (NIH);

19 (2) An NIH cooperative group or center as defined in
20 subsection 7 of this section;

21 (3) The FDA in the form of an investigational new drug
22 application;

23 (4) The federal Departments of Veterans' Affairs or
24 Defense;

25 (5) An institutional review board in this state that has an
26 appropriate assurance approved by the Department of Health and
27 Human Services assuring compliance with and implementation of
28 regulations for the protection of human subjects (45 CFR 46); or

1 (6) A qualified research entity that meets the criteria for
2 NIH Center support grant eligibility.

3 5. Subsections 1 and 2 of this section requiring coverage
4 for routine patient care costs shall apply to phase II of
5 clinical trials if:

6 (1) Phase II of a clinical trial is sanctioned by the
7 National Institutes of Health (NIH) or National Cancer Institute
8 (NCI) and conducted at academic or National Cancer Institute
9 Center; and

10 (2) The person covered under this section is enrolled in
11 the clinical trial. This section shall not apply to persons who
12 are only following the protocol of phase II of a clinical trial,
13 but not actually enrolled.

14 6. An entity seeking coverage for treatment, prevention, or
15 early detection in a clinical trial approved by an institutional
16 review board under subdivision (5) of subsection 4 of this
17 section shall maintain and post electronically a list of the
18 clinical trials meeting the requirements of subsections 2 and 3
19 of this section. This list shall include: the phase for which
20 the clinical trial is approved; the entity approving the trial;
21 the particular disease; and the number of participants in the
22 trial. If the electronic posting is not practical, the entity
23 seeking coverage shall periodically provide payers and providers
24 in the state with a written list of trials providing the
25 information required in this section.

26 7. As used in this section, the following terms shall mean:

27 (1) "Cooperative group", a formal network of facilities
28 that collaborate on research projects and have an established

1 NIH-approved Peer Review Program operating within the group,
2 including the NCI Clinical Cooperative Group and the NCI
3 Community Clinical Oncology Program;

4 (2) "Multiple project assurance contract", a contract
5 between an institution and the federal Department of Health and
6 Human Services (DHHS) that defines the relationship of the
7 institution to the DHHS and sets out the responsibilities of the
8 institution and the procedures that will be used by the
9 institution to protect human subjects;

10 (3) "Routine patient care costs" shall include coverage for
11 reasonable and medically necessary services needed to administer
12 the drug or device under evaluation in the clinical trial.

13 Routine patient care costs include all items and services that
14 are otherwise generally available to a qualified individual that
15 are provided in the clinical trial except:

16 (a) The investigational item or service itself;

17 (b) Items and services provided solely to satisfy data
18 collection and analysis needs and that are not used in the direct
19 clinical management of the patient; and

20 (c) Items and services customarily provided by the research
21 sponsors free of charge for any enrollee in the trial.

22 8. For the purpose of this section, providers participating
23 in clinical trials shall obtain a patient's informed consent for
24 participation on the clinical trial in a manner that is
25 consistent with current legal and ethical standards. Such
26 documents shall be made available to the health insurer upon
27 request.

28 9. The provisions of this section shall not apply to a

1 policy, plan or contract paid under Title XVIII or Title XIX of
2 the Social Security Act.

3 10. Nothing in this section shall apply to any
4 accident-only policy, specified disease policy, hospital
5 indemnity policy, Medicare supplement policy, long-term care
6 policy, short-term major medical policy [of six months or less]
7 with a duration of less than one year, or other limited benefit
8 health insurance policies.

9 11. The provisions of this section regarding phase II of a
10 clinical trial shall not apply automatically to an individually
11 underwritten health benefit plan, but shall be an option to any
12 such plan.

13 376.446. 1. Health carriers shall permit individuals to
14 learn the amount of cost-sharing, including deductibles,
15 copayments, and coinsurance, under the individual's health
16 benefit plan or coverage that the individual would be responsible
17 for paying with respect to the furnishing of a specific item or
18 service by a participating provider in a timely manner upon the
19 request of the individual. At a minimum, such information shall
20 be made available to such individual through an internet website
21 and such other means for individuals without access to the
22 internet. As used in this section, the terms "health carrier"
23 and "health benefit plans" shall have the same meanings assigned
24 to them in section 376.1350.

25 2. Health carriers shall permit individuals to learn the
26 amount of cost-sharing, including deductibles, copayments, and
27 coinsurance, under an individual's short-term major medical
28 policy with a duration of less than one year that the individual

1 would be responsible for paying with respect to the furnishing of
2 a specific item or service by a participating provider in a
3 timely manner upon the request of the individual. At a minimum,
4 such information shall be made available to such individual
5 through an internet website and such other means for individuals
6 without access to the internet.

7 3. This section shall not apply to a supplemental insurance
8 policy, including a life care contract, accident-only policy,
9 specified disease policy, hospital policy providing a fixed daily
10 benefit only, Medicare supplement policy, long-term care policy,
11 hospitalization-surgical care policy, [short-term major medical
12 policy of six months or less duration,] or any other supplemental
13 policy.

14 [3. The provisions of subsections 1 and 2 shall become
15 effective on January 1, 2014.]

16 376.452. 1. Except as provided in this section, if a
17 health insurance issuer offers health insurance coverage in the
18 large group market in connection with a group health plan, the
19 health insurance issuer shall renew or continue the coverage in
20 force at the option of the plan sponsor. The provisions of this
21 subsection shall not apply to short-term major medical policies
22 with durations of less than one year.

23 2. A health insurance issuer may nonrenew or discontinue
24 health insurance coverage offered in connection with a group
25 health plan in the large group market if:

26 (1) The plan sponsor has failed to pay premiums or
27 contributions in accordance with the terms of the health
28 insurance coverage or if the health insurance issuer has not

1 received timely premium payments;

2 (2) The plan sponsor has performed an act or practice that
3 constitutes fraud or has made an intentional misrepresentation of
4 material fact under the terms of the coverage;

5 (3) The plan sponsor has failed to comply with the health
6 insurance issuer's minimum participation requirements;

7 (4) The plan sponsor has failed to comply with the health
8 insurance issuer's employer contribution requirements;

9 (5) The health insurance issuer is ceasing to offer
10 coverage in the large group market in accordance with subsection
11 3 of this section;

12 (6) In the case of a health insurance issuer that offers
13 health insurance coverage in the large group market through a
14 network plan, there is no longer any enrollee under the group
15 health plan who lives, resides, or works in the service area of
16 the health insurance issuer or in the area for which the issuer
17 is authorized to do business;

18 (7) In the case of health insurance coverage that is made
19 available in the large group market only through one or more bona
20 fide associations, the membership of an employer in the bona fide
21 association ceases, but only if coverage is terminated under this
22 subdivision uniformly without regard to any health status-related
23 factor of any covered individual.

24 3. A health insurance issuer shall not discontinue offering
25 a particular type of group health insurance coverage offered in
26 the large group market unless:

27 (1) The issuer provides notice to each plan sponsor,
28 participant and beneficiary provided coverage of this type in the

1 large group market of the discontinuation at least ninety days
2 prior to the date of the discontinuation of the coverage;

3 (2) The issuer offers to each plan sponsor being provided
4 coverage of this type in the large group market the option to
5 purchase any other health insurance coverage currently being
6 offered by the health insurance issuer to a group health plan in
7 the large group market; and

8 (3) The issuer acts uniformly without regard to the claims
9 experience of those plan sponsors or any health status-related
10 factor of any participant or beneficiary covered or new
11 participant or beneficiary who may become eligible for such
12 coverage.

13 4. (1) A health insurance issuer shall not discontinue
14 offering all health insurance coverage in the large group market
15 unless:

16 (a) The issuer provides notice of discontinuation to the
17 director and to each plan sponsor, participant and beneficiary
18 covered at least one hundred eighty days prior to the date of the
19 discontinuation of coverage; and

20 (b) All health insurance issued or delivered for issuance
21 in Missouri in the large group market is discontinued and
22 coverage under such health insurance is not renewed.

23 (2) In the case of a discontinuation under this subsection,
24 the health insurance issuer shall not provide for the issuance of
25 any health insurance coverage in the large group market for a
26 period of five years beginning on the date of the discontinuation
27 of the last health insurance coverage not renewed.

28 5. At the time of coverage renewal, a health insurance

1 issuer may modify the health insurance coverage for a product
2 offered to a group health plan in the large group market. For
3 purposes of this subsection, renewal shall be deemed to occur not
4 more often than annually on the anniversary of the effective date
5 of the group health plan's health insurance coverage unless a
6 longer term is specified in the policy or contract.

7 6. In the case of health insurance coverage that is made
8 available by a health insurance issuer only through one or more
9 bona fide associations, a reference to plan sponsor in this
10 section is deemed, with respect to coverage provided to an
11 employer member of the association, to include a reference to
12 such employer.

13 376.454. 1. Except as provided in this section, a health
14 insurance issuer that provides individual health insurance
15 coverage to an individual shall renew or continue in force such
16 coverage at the option of the individual. The provisions of this
17 subsection shall not apply to short-term major medical policies
18 with durations of less than one year.

19 2. A health insurance issuer may nonrenew or discontinue
20 health insurance coverage of an individual in the individual
21 market based only on one or more of the following:

22 (1) The individual has failed to pay premiums or
23 contributions in accordance with the terms of the health
24 insurance coverage or the issuer has not received timely premium
25 payments;

26 (2) The individual has performed an act or practice that
27 constitutes fraud or made an intentional misrepresentation of
28 material fact under the terms of the coverage;

1 (3) The issuer is ceasing to offer coverage in the
2 individual market in accordance with subsection 4 of this
3 section;

4 (4) In the case of a health insurance issuer that offers
5 health insurance coverage in the market through a network plan,
6 the individual no longer resides, lives, or works in the service
7 area or in an area for which the issuer is authorized to do
8 business but only if such coverage is terminated under this
9 subdivision uniformly without regard to any health status-related
10 factor of covered individuals;

11 (5) In the case of health insurance coverage that is made
12 available in the individual market only through one or more bona
13 fide associations, the membership of the individual in the
14 association on the basis of which the coverage is provided
15 ceases, but only if such coverage is terminated under this
16 subdivision uniformly without regard to any health status-related
17 factor of covered individuals.

18 3. In any case in which an issuer decides to discontinue
19 offering a particular type of health insurance coverage offered
20 in the individual market, coverage of such type may be
21 discontinued by the issuer only if:

22 (1) The issuer provides notice to each covered individual
23 provided coverage of this type in such market of such
24 discontinuation at least ninety days prior to the date of the
25 discontinuation of such coverage;

26 (2) The issuer offers to each individual in the individual
27 market provided coverage of this type, the option to purchase any
28 other individual health insurance coverage currently being

1 offered by the issuer for individuals in such market; and

2 (3) In exercising the option to discontinue coverage of
3 this type and in offering the option of coverage under
4 subdivision (2) of this subsection, the issuer acts uniformly
5 without regard to any health status-related factor of enrolled
6 individuals or individuals who may become eligible for such
7 coverage.

8 4. (1) In any case in which a health insurance issuer
9 elects to discontinue offering all health insurance coverage in
10 the individual market in the state, health insurance coverage may
11 be discontinued by the issuer only if:

12 (a) The issuer provides notice to the director and to each
13 individual of such discontinuation at least one hundred eighty
14 days prior to the date of the expiration of such coverage; and

15 (b) All health insurance issued or delivered for issuance
16 in the state in such market is discontinued and coverage under
17 such health insurance coverage in such market is not renewed.

18 (2) In the case of a discontinuation under subdivision (1)
19 of this subsection, the issuer shall not provide for the issuance
20 of any health insurance coverage in the individual market for a
21 five-year period beginning on the date of the discontinuation of
22 the last health insurance coverage not so renewed.

23 5. At the time of coverage renewal, a health insurance
24 issuer may modify the health insurance coverage for a policy form
25 offered to individuals in the individual market so long as such
26 modification is consistent with applicable law and effective on a
27 uniform basis among all individuals with that policy form. For
28 purposes of this subsection, renewal shall be deemed to occur not

1 more often than annually on the anniversary of the effective date
2 of the individual's health insurance coverage or as specified in
3 the policy or contract.

4 6. In applying this section in the case of health insurance
5 coverage that is made available by a health insurance issuer in
6 the individual market to individuals only through one or more
7 associations, a reference to an individual is deemed to include a
8 reference to such an association of which the individual is a
9 member.

10 7. An insurer shall provide a certification of creditable
11 coverage as required by Public Law 104-191 and regulations
12 pursuant thereto.

13 376.779. 1. All health plans or policies that are
14 individually underwritten or provide for such coverage for
15 specific individuals and the members of their families, which
16 provide for hospital treatment, shall provide coverage, while
17 confined in a hospital or in a residential or nonresidential
18 facility certified by the department of mental health, for
19 treatment of alcoholism on the same basis as coverage for any
20 other illness, except that coverage may be limited to thirty days
21 in any policy or contract benefit period. All Missouri
22 individual contracts issued on or after January 1, 2005, shall be
23 subject to this section. Coverage required by this section shall
24 be included in the policy or contract and payment provided as for
25 other coverage in the same policy or contract notwithstanding any
26 construction or relationship of interdependent contracts or plans
27 affecting coverage and payment of reimbursement prerequisites
28 under the policy or contract.

1 2. Insurers, corporations or groups providing coverage may
2 approve for payment or reimbursement vendors and programs
3 providing services or treatment required by this section. Any
4 vendor or person offering services or treatment subject to the
5 provisions of this section and seeking approval for payment or
6 reimbursement shall submit to the department of mental health a
7 detailed description of the services or treatment program to be
8 offered. The department of mental health shall make copies of
9 such descriptions available to insurers, corporations or groups
10 providing coverage under the provisions of this section. Each
11 insurer, corporation or group providing coverage shall notify the
12 vendor or person offering service or treatment as to its
13 acceptance or rejection for payment or reimbursement; provided,
14 however, payment or reimbursement shall be made for any service
15 or treatment program certified by the department of mental
16 health. Any notice of rejection shall contain a detailed
17 statement of the reasons for rejection and the steps and
18 procedures necessary for acceptance. Amended descriptions of
19 services or treatment programs to be offered may be filed with
20 the department of mental health. Any vendor or person rejected
21 for approval of payment or reimbursement may modify their
22 description and treatment program and submit copies of the
23 amended description to the department of mental health and to the
24 insurer, corporation or group which rejected the original
25 description.

26 3. The department of mental health may issue rules
27 necessary to carry out the provisions of this section. No rule
28 or portion of a rule promulgated under the authority of this

1 section shall become effective unless it has been promulgated
2 pursuant to the provisions of section 536.024.

3 4. All substance abuse treatment programs in Missouri
4 receiving funding from the Missouri department of mental health
5 must be certified by the department.

6 5. This section shall not apply to a supplemental insurance
7 policy, including a life care contract, accident-only policy,
8 specified disease policy, hospital policy providing a fixed daily
9 benefit only, Medicare supplement policy, long-term care policy,
10 hospitalization-surgical care policy, short-term major medical
11 policy [of six months or less] with a duration of less than one
12 year, or any other supplemental policy as determined by the
13 director of the department of insurance, financial institutions
14 and professional registration.

15 376.781. 1. All group health insurance policies providing
16 coverage on an expense-incurred basis, all group service or
17 indemnity contracts issued by a not-for-profit health service
18 corporation, all self-insured group health benefit plans of any
19 type or description, and all such health plans or policies that
20 are individually underwritten or provide for such coverage for
21 specific individuals and the members of their families as
22 nongroup policies, which provide for hospital treatment, shall
23 offer coverage for the necessary care and treatment of loss or
24 impairment of speech or hearing subject to the same durational
25 limits, dollar limits, deductibles and coinsurance factors as
26 other covered services in such policies or contracts. All
27 Missouri group contracts issued or renewed on or after December
28 31, 1984, shall be subject to this section. Notwithstanding any

1 construction or relationship of interdependent contracts or plans
2 affecting coverage and payment of reimbursement prerequisites
3 under the policy or contract, coverage required by this section
4 shall be included in the policy or contract and payment provided
5 as for other coverage in the same policy or contract.

6 2. The offer of benefits under subsection 1 of this section
7 shall be in writing and may be rejected by the individual or
8 group policyholder.

9 3. Nothing in this section shall prohibit the insurance
10 company or not-for-profit health service corporation from
11 including any coverage for loss or impairment of speech, language
12 or hearing as standard coverage in their policies or contracts,
13 but same shall not contain terms contrary to this section.

14 4. The phrase "loss or impairment of speech or hearing"
15 shall include those communicative disorders generally treated by
16 a speech pathologist, audiologist or speech/language pathologist
17 licensed by the state board of healing arts or certified by the
18 American Speech-Language and Hearing Association (ASHA), or both,
19 and which fall within the scope of his or her license or
20 certification.

21 5. Any provision in a health insurance policy contrary to
22 or in conflict with the provisions of this section shall, to the
23 extent of the conflict, be void, but such invalidity shall not
24 offset the validity of the other provisions of such policy.

25 6. The provisions of this section shall not apply to short-
26 term major medical policies with durations of less than one year.

27 7. The department of insurance, financial institutions and
28 professional registration may issue rules necessary to carry out

1 the provisions of this section. No rule or portion of a rule
2 promulgated under the authority of this section shall become
3 effective unless it has been promulgated pursuant to the
4 provisions of section 536.024.

5 376.782. 1. As used in this section, the term "low-dose
6 mammography screening" means the X-ray examination of the breast
7 using equipment specifically designed and dedicated for
8 mammography, including the X-ray tube, filter, compression
9 device, films, and cassettes, with an average radiation exposure
10 delivery of less than one rad mid-breast, with two views for each
11 breast, and any fee charged by a radiologist or other physician
12 for reading, interpreting or diagnosing based on such X-ray.

13 2. All individual and group health insurance policies
14 providing coverage on an expense-incurred basis, individual and
15 group service or indemnity type contracts issued by a nonprofit
16 corporation, individual and group service contracts issued by a
17 health maintenance organization, all self-insured group
18 arrangements to the extent not preempted by federal law and all
19 managed health care delivery entities of any type or description,
20 that are delivered, issued for delivery, continued or renewed on
21 or after August 28, 1991, and providing coverage to any resident
22 of this state shall provide benefits or coverage for low-dose
23 mammography screening for any nonsymptomatic woman covered under
24 such policy or contract which meets the minimum requirements of
25 this section. Such benefits or coverage shall include at least
26 the following:

27 (1) A baseline mammogram for women age thirty-five to
28 thirty-nine, inclusive;

1 (2) A mammogram for women age forty to forty-nine,
2 inclusive, every two years or more frequently based on the
3 recommendation of the patient's physician;

4 (3) A mammogram every year for women age fifty and over;

5 (4) A mammogram for any woman, upon the recommendation of a
6 physician, where such woman, her mother or her sister has a prior
7 history of breast cancer.

8 3. Coverage and benefits related to mammography as required
9 by this section shall be at least as favorable and subject to the
10 same dollar limits, deductibles, and co-payments as other
11 radiological examinations.

12 4. The provisions of this section shall not apply to short-
13 term major medical policies with durations of less than one year.

14 376.811. 1. Every insurance company and health services
15 corporation doing business in this state shall offer in all
16 health insurance policies benefits or coverage for chemical
17 dependency meeting the following minimum standards:

18 (1) Coverage for outpatient treatment through a
19 nonresidential treatment program, or through partial- or full-day
20 program services, of not less than twenty-six days per policy
21 benefit period;

22 (2) Coverage for residential treatment program of not less
23 than twenty-one days per policy benefit period;

24 (3) Coverage for medical or social setting detoxification
25 of not less than six days per policy benefit period;

26 (4) The coverages set forth in this subsection may be
27 subject to a separate lifetime frequency cap of not less than ten
28 episodes of treatment, except that such separate lifetime

1 frequency cap shall not apply to medical detoxification in a
2 life-threatening situation as determined by the treating
3 physician and subsequently documented within forty-eight hours of
4 treatment to the reasonable satisfaction of the insurance company
5 or health services corporation; and

6 (5) The coverages set forth in this subsection:

7 (a) Shall be subject to the same coinsurance, co-payment
8 and deductible factors as apply to physical illness;

9 (b) May be administered pursuant to a managed care program
10 established by the insurance company or health services
11 corporation; and

12 (c) May deliver covered services through a system of
13 contractual arrangements with one or more providers, hospitals,
14 nonresidential or residential treatment programs, or other mental
15 health service delivery entities certified by the department of
16 mental health, or accredited by a nationally recognized
17 organization, or licensed by the state of Missouri.

18 2. In addition to the coverages set forth in subsection 1
19 of this section, every insurance company, health services
20 corporation and health maintenance organization doing business in
21 this state shall offer in all health insurance policies, benefits
22 or coverages for recognized mental illness, excluding chemical
23 dependency, meeting the following minimum standards:

24 (1) Coverage for outpatient treatment, including treatment
25 through partial- or full-day program services, for mental health
26 services for a recognized mental illness rendered by a licensed
27 professional to the same extent as any other illness;

28 (2) Coverage for residential treatment programs for the

1 therapeutic care and treatment of a recognized mental illness
2 when prescribed by a licensed professional and rendered in a
3 psychiatric residential treatment center licensed by the
4 department of mental health or accredited by the Joint Commission
5 on Accreditation of Hospitals to the same extent as any other
6 illness;

7 (3) Coverage for inpatient hospital treatment for a
8 recognized mental illness to the same extent as for any other
9 illness, not to exceed ninety days per year;

10 (4) The coverages set forth in this subsection shall be
11 subject to the same coinsurance, co-payment, deductible, annual
12 maximum and lifetime maximum factors as apply to physical
13 illness; and

14 (5) The coverages set forth in this subsection may be
15 administered pursuant to a managed care program established by
16 the insurance company, health services corporation or health
17 maintenance organization, and covered services may be delivered
18 through a system of contractual arrangements with one or more
19 providers, community mental health centers, hospitals,
20 nonresidential or residential treatment programs, or other mental
21 health service delivery entities certified by the department of
22 mental health, or accredited by a nationally recognized
23 organization, or licensed by the state of Missouri.

24 3. The offer required by sections 376.810 to 376.814 may be
25 accepted or rejected by the group or individual policyholder or
26 contract holder and, if accepted, shall fully and completely
27 satisfy and substitute for the coverage under section 376.779.
28 Nothing in sections 376.810 to 376.814 shall prohibit an

1 insurance company, health services corporation or health
2 maintenance organization from including all or part of the
3 coverages set forth in sections 376.810 to 376.814 as standard
4 coverage in their policies or contracts issued in this state.

5 4. Every insurance company, health services corporation and
6 health maintenance organization doing business in this state
7 shall offer in all health insurance policies mental health
8 benefits or coverage as part of the policy or as a supplement to
9 the policy. Such mental health benefits or coverage shall
10 include at least two sessions per year to a licensed
11 psychiatrist, licensed psychologist, licensed professional
12 counselor, licensed clinical social worker, or, subject to
13 contractual provisions, a licensed marital and family therapist,
14 acting within the scope of such license and under the following
15 minimum standards:

16 (1) Coverage and benefits in this subsection shall be for
17 the purpose of diagnosis or assessment, but not dependent upon
18 findings; and

19 (2) Coverage and benefits in this subsection shall not be
20 subject to any conditions of preapproval, and shall be deemed
21 reimbursable as long as the provisions of this subsection are
22 satisfied; and

23 (3) Coverage and benefits in this subsection shall be
24 subject to the same coinsurance, co-payment and deductible
25 factors as apply to regular office visits under coverages and
26 benefits for physical illness.

27 5. If the group or individual policyholder or contract
28 holder rejects the offer required by this section, then the

1 coverage shall be governed by the mental health and chemical
2 dependency insurance act as provided in sections 376.825 to
3 376.836.

4 6. This section shall not apply to a supplemental insurance
5 policy, including a life care contract, accident-only policy,
6 specified disease policy, hospital policy providing a fixed daily
7 benefit only, Medicare supplement policy, long-term care policy,
8 hospitalization-surgical care policy, short-term major medical
9 policy [of six months or less] with a duration of less than one
10 year, or any other supplemental policy as determined by the
11 director of the department of insurance, financial institutions
12 and professional registration.

13 376.845. 1. For the purposes of this section the following
14 terms shall mean:

15 (1) "Eating disorder", pica, rumination disorder,
16 avoidant/restrictive food intake disorder, anorexia nervosa,
17 bulimia nervosa, binge eating disorder, other specified feeding
18 or eating disorder, and any other eating disorder contained in
19 the most recent version of the Diagnostic and Statistical Manual
20 of Mental Disorders published by the American Psychiatric
21 Association where diagnosed by a licensed physician,
22 psychiatrist, psychologist, clinical social worker, licensed
23 marital and family therapist, or professional counselor duly
24 licensed in the state where he or she practices and acting within
25 their applicable scope of practice in the state where he or she
26 practices;

27 (2) "Health benefit plan", shall have the same meaning as
28 such term is defined in section 376.1350; however, for purposes

1 of this section "health benefit plan" does not include a
2 supplemental insurance policy, including a life care contract,
3 accident-only policy, specified disease policy, hospital policy
4 providing a fixed daily benefit only, Medicare supplement policy,
5 long-term care policy, short-term major medical policy [of six
6 months or less] with a duration of less than one year, or any
7 other supplemental policy;

8 (3) "Health carrier", shall have the same meaning as such
9 term is defined in section 376.1350;

10 (4) "Medical care", health care services needed to
11 diagnose, prevent, treat, cure, or relieve physical
12 manifestations of an eating disorder, and shall include inpatient
13 hospitalization, partial hospitalization, residential care,
14 intensive outpatient treatment, follow-up outpatient care, and
15 counseling;

16 (5) "Pharmacy care", medications prescribed by a licensed
17 physician for an eating disorder and includes any health-related
18 services deemed medically necessary to determine the need or
19 effectiveness of the medications, but only to the extent that
20 such medications are included in the insured's health benefit
21 plan;

22 (6) "Psychiatric care" and "psychological care", direct or
23 consultative services provided during inpatient hospitalization,
24 partial hospitalization, residential care, intensive outpatient
25 treatment, follow-up outpatient care, and counseling provided by
26 a psychiatrist or psychologist licensed in the state of practice;

27 (7) "Therapy", medical care and behavioral interventions
28 provided by a duly licensed physician, psychiatrist,

1 psychologist, professional counselor, licensed clinical social
2 worker, or family marriage therapist where said person is
3 licensed or registered in the states where he or she practices;

4 (8) "Treatment of eating disorders", therapy provided by a
5 licensed treating physician, psychiatrist, psychologist,
6 professional counselor, clinical social worker, or licensed
7 marital and family therapist pursuant to the powers granted under
8 such licensed physician's, psychiatrist's, psychologist's,
9 professional counselor's, clinical social worker's, or licensed
10 marital and family therapist's license in the state where he or
11 she practices for an individual diagnosed with an eating
12 disorder.

13 2. In accordance with the provisions of section 376.1550,
14 all health benefit plans that are delivered, issued for delivery,
15 continued or renewed on or after January 1, 2017, if written
16 inside the state of Missouri, or written outside the state of
17 Missouri but covering Missouri residents, shall provide coverage
18 for the diagnosis and treatment of eating disorders as required
19 in section 376.1550.

20 3. Coverage provided under this section is limited to
21 medically necessary treatment that is provided by a licensed
22 treating physician, psychiatrist, psychologist, professional
23 counselor, clinical social worker, or licensed marital and family
24 therapist pursuant to the powers granted under such licensed
25 physician's, psychiatrist's, psychologist's, professional
26 counselor's, clinical social worker's, or licensed marital and
27 family therapist's license and acting within their applicable
28 scope of coverage, in accordance with a treatment plan.

1 4. The treatment plan, upon request by the health benefit
2 plan or health carrier, shall include all elements necessary for
3 the health benefit plan or health carrier to pay claims. Such
4 elements include, but are not limited to, a diagnosis, proposed
5 treatment by type, frequency and duration of treatment, and
6 goals.

7 5. Coverage of the treatment of eating disorders may be
8 subject to other general exclusions and limitations of the
9 contract or benefit plan not in conflict with the provisions of
10 this section, such as coordination of benefits, and utilization
11 review of health care services, which includes reviews of medical
12 necessity and care management. Medical necessity determinations
13 and care management for the treatment of eating disorders shall
14 consider the overall medical and mental health needs of the
15 individual with an eating disorder, shall not be based solely on
16 weight, and shall take into consideration the most recent
17 Practice Guideline for the Treatment of Patients with Eating
18 Disorders adopted by the American Psychiatric Association in
19 addition to current standards based upon the medical literature
20 generally recognized as authoritative in the medical community.

21 376.1199. 1. Each health carrier or health benefit plan
22 that offers or issues health benefit plans providing
23 obstetrical/gynecological benefits and pharmaceutical coverage,
24 which are delivered, issued for delivery, continued or renewed in
25 this state on or after January 1, 2002, shall:

26 (1) Notwithstanding the provisions of subsection 4 of
27 section 354.618, provide enrollees with direct access to the
28 services of a participating obstetrician, participating

1 gynecologist or participating obstetrician/gynecologist of her
2 choice within the provider network for covered services. The
3 services covered by this subdivision shall be limited to those
4 services defined by the published recommendations of the
5 accreditation council for graduate medical education for training
6 an obstetrician, gynecologist or obstetrician/gynecologist,
7 including but not limited to diagnosis, treatment and referral
8 for such services. A health carrier shall not impose additional
9 co-payments, coinsurance or deductibles upon any enrollee who
10 seeks or receives health care services pursuant to this
11 subdivision, unless similar additional co-payments, coinsurance
12 or deductibles are imposed for other types of health care
13 services received within the provider network. Nothing in this
14 subsection shall be construed to require a health carrier to
15 perform, induce, pay for, reimburse, guarantee, arrange, provide
16 any resources for or refer a patient for an abortion, as defined
17 in section 188.015, other than a spontaneous abortion or to
18 prevent the death of the female upon whom the abortion is
19 performed, or to supersede or conflict with section 376.805; and

20 (2) Notify enrollees annually of cancer screenings covered
21 by the enrollees' health benefit plan and the current American
22 Cancer Society guidelines for all cancer screenings or notify
23 enrollees at intervals consistent with current American Cancer
24 Society guidelines of cancer screenings which are covered by the
25 enrollees' health benefit plans. The notice shall be delivered
26 by mail unless the enrollee and health carrier have agreed on
27 another method of notification; and

28 (3) Include coverage for services related to diagnosis,

1 treatment and appropriate management of osteoporosis when such
2 services are provided by a person licensed to practice medicine
3 and surgery in this state, for individuals with a condition or
4 medical history for which bone mass measurement is medically
5 indicated for such individual. In determining whether testing or
6 treatment is medically appropriate, due consideration shall be
7 given to peer-reviewed medical literature. A policy, provision,
8 contract, plan or agreement may apply to such services the same
9 deductibles, coinsurance and other limitations as apply to other
10 covered services; and

11 (4) If the health benefit plan also provides coverage for
12 pharmaceutical benefits, provide coverage for contraceptives
13 either at no charge or at the same level of deductible,
14 coinsurance or co-payment as any other covered drug.

15
16 No such deductible, coinsurance or co-payment shall be greater
17 than any drug on the health benefit plan's formulary. As used in
18 this section, "contraceptive" shall include all prescription
19 drugs and devices approved by the federal Food and Drug
20 Administration for use as a contraceptive, but shall exclude all
21 drugs and devices that are intended to induce an abortion, as
22 defined in section 188.015, which shall be subject to section
23 376.805. Nothing in this subdivision shall be construed to
24 exclude coverage for prescription contraceptive drugs or devices
25 ordered by a health care provider with prescriptive authority for
26 reasons other than contraceptive or abortion purposes.

27 2. For the purposes of this section, "health carrier" and
28 "health benefit plan" shall have the same meaning as defined in

1 section 376.1350.

2 3. The provisions of this section shall not apply to a
3 supplemental insurance policy, including a life care contract,
4 accident-only policy, specified disease policy, hospital policy
5 providing a fixed daily benefit only, Medicare supplement policy,
6 long-term care policy, short-term major medical [policies of six
7 months or less] policy with a duration of less than one year, or
8 any other supplemental policy as determined by the director of
9 the department of insurance, financial institutions and
10 professional registration.

11 4. Notwithstanding the provisions of subdivision (4) of
12 subsection 1 of this section to the contrary:

13 (1) Any health carrier shall offer and issue to any person
14 or entity purchasing a health benefit plan, a health benefit plan
15 that excludes coverage for contraceptives if the use or provision
16 of such contraceptives is contrary to the moral, ethical or
17 religious beliefs or tenets of such person or entity;

18 (2) Upon request of an enrollee who is a member of a group
19 health benefit plan and who states that the use or provision of
20 contraceptives is contrary to his or her moral, ethical or
21 religious beliefs, any health carrier shall issue to or on behalf
22 of such enrollee a policy form that excludes coverage for
23 contraceptives. Any administrative costs to a group health
24 benefit plan associated with such exclusion of coverage not
25 offset by the decreased costs of providing coverage shall be
26 borne by the group policyholder or group plan holder;

27 (3) Any health carrier which is owned, operated or
28 controlled in substantial part by an entity that is operated

1 pursuant to moral, ethical or religious tenets that are contrary
2 to the use or provision of contraceptives shall be exempt from
3 the provisions of subdivision (4) of subsection 1 of this
4 section. For purposes of this subsection, if new premiums are
5 charged for a contract, plan or policy, it shall be determined to
6 be a new contract, plan or policy.

7 5. Except for a health carrier that is exempted from
8 providing coverage for contraceptives pursuant to this section, a
9 health carrier shall allow enrollees in a health benefit plan
10 that excludes coverage for contraceptives pursuant to subsection
11 4 of this section to purchase a health benefit plan that includes
12 coverage for contraceptives.

13 6. Any health benefit plan issued pursuant to subsection 1
14 of this section shall provide clear and conspicuous written
15 notice on the enrollment form or any accompanying materials to
16 the enrollment form and the group health benefit plan application
17 and contract:

18 (1) Whether coverage for contraceptives is or is not
19 included;

20 (2) That an enrollee who is a member of a group health
21 benefit plan with coverage for contraceptives has the right to
22 exclude coverage for contraceptives if such coverage is contrary
23 to his or her moral, ethical or religious beliefs;

24 (3) That an enrollee who is a member of a group health
25 benefit plan without coverage for contraceptives has the right to
26 purchase coverage for contraceptives;

27 (4) Whether an optional rider for elective abortions has
28 been purchased by the group contract holder pursuant to section

1 376.805; and

2 (5) That an enrollee who is a member of a group health plan
3 with coverage for elective abortions has the right to exclude and
4 not pay for coverage for elective abortions if such coverage is
5 contrary to his or her moral, ethical, or religious beliefs.

6
7 For purposes of this subsection, if new premiums are charged for
8 a contract, plan, or policy, it shall be determined to be a new
9 contract, plan, or policy.

10 7. Health carriers shall not disclose to the person or
11 entity who purchased the health benefit plan the names of
12 enrollees who exclude coverage for contraceptives in the health
13 benefit plan or who purchase a health benefit plan that includes
14 coverage for contraceptives. Health carriers and the person or
15 entity who purchased the health benefit plan shall not
16 discriminate against an enrollee because the enrollee excluded
17 coverage for contraceptives in the health benefit plan or
18 purchased a health benefit plan that includes coverage for
19 contraceptives.

20 8. The departments of health and senior services and
21 insurance, financial institutions and professional registration
22 may promulgate rules necessary to implement the provisions of
23 this section. No rule or portion of a rule promulgated pursuant
24 to this section shall become effective unless it has been
25 promulgated pursuant to chapter 536. Any rule or portion of a
26 rule, as that term is defined in section 536.010, that is created
27 under the authority delegated in this section shall become
28 effective only if it complies with and is subject to all of the

1 provisions of chapter 536 and, if applicable, section 536.028.
2 This section and chapter 536 are nonseverable and if any of the
3 powers vested with the general assembly pursuant to chapter 536
4 to review, to delay the effective date or to disapprove and annul
5 a rule are subsequently held unconstitutional, then the grant of
6 rulemaking authority and any rule proposed or adopted after
7 August 28, 2001, shall be invalid and void.

8 376.1200. 1. Each entity offering individual and group
9 health insurance policies providing coverage on an
10 expense-incurred basis, individual and group service or indemnity
11 type contracts issued by a health services corporation,
12 individual and group service contracts issued by a health
13 maintenance organization, all self-insured group arrangements to
14 the extent not preempted by federal law and all managed health
15 care delivery entities of any type or description, that are
16 delivered, issued for delivery, continued or renewed in this
17 state on or after January 1, 1996, shall offer coverage for the
18 treatment of breast cancer by dose-intensive
19 chemotherapy/autologous bone marrow transplants or stem cell
20 transplants when performed pursuant to nationally accepted peer
21 review protocols utilized by breast cancer treatment centers
22 experienced in dose-intensive chemotherapy/autologous bone marrow
23 transplants or stem cell transplants. The offer of benefits
24 under this section shall be in writing and must be accepted in
25 writing by the individual or group policyholder or contract
26 holder.

27 2. Such health care service shall not be subject to any
28 greater deductible or co-payment than any other health care

1 service provided by the policy, contract or plan, except that the
2 policy, contract or plan may contain a provision imposing a
3 lifetime benefit maximum of not less than one hundred thousand
4 dollars, for dose-intensive chemotherapy/autologous bone marrow
5 transplants or stem cell transplants for breast cancer treatment.

6 3. Benefits may be administered for such health care
7 service through a managed care program of exclusive and/or
8 preferred contractual arrangements with one or more providers
9 rendering such health care service. These contractual
10 arrangements may provide that the provider shall hold the patient
11 harmless for the cost of rendering such health care service if it
12 is subsequently found by the entity authorized to resolve
13 disputes that:

14 (1) Such care did not qualify under the protocols
15 established for the providing of care for such health care
16 service;

17 (2) Such care was not medically appropriate; or

18 (3) The provider otherwise failed to comply with the
19 utilization management or other managed care provision agreed to
20 in any contract between the entity and the provider.

21 4. The provisions of this section shall not apply to
22 short-term travel, accident-only, limited or specified disease
23 policies, short-term major medical policies with durations of
24 less than one year, or to short-term nonrenewable policies of not
25 more than seven months duration.

26 5. Nothing in this section shall prohibit an entity from
27 including all or part of such health care services as standard
28 coverage in its policies, contracts or plans.

1 376.1209. 1. Each entity offering individual and group
2 health insurance policies providing coverage on an
3 expense-incurred basis, individual and group service or indemnity
4 type contracts issued by a nonprofit corporation, individual and
5 group service contracts issued by a health maintenance
6 organization, all self-insured group arrangements to the extent
7 not preempted by federal law, and all managed health care
8 delivery entities of any type or description, that provide
9 coverage for the surgical procedure known as a mastectomy, and
10 which are delivered, issued for delivery, continued or renewed in
11 this state on or after January 1, 1998, shall provide coverage
12 for prosthetic devices or reconstructive surgery necessary to
13 restore symmetry as recommended by the oncologist or primary care
14 physician for the patient incident to the mastectomy. Coverage
15 for prosthetic devices and reconstructive surgery shall be
16 subject to the same deductible and coinsurance conditions applied
17 to the mastectomy and all other terms and conditions applicable
18 to other benefits with the exception that no time limit shall be
19 imposed on an individual for the receipt of prosthetic devices or
20 reconstructive surgery and if such individual changes his or her
21 insurer, then the new policy subject to the federal Women's
22 Health and Cancer Rights Act (Sections 901-903 of P.L. 105-277),
23 as amended, shall provide coverage consistent with the federal
24 Women's Health and Cancer Rights Act (Sections 901-903 of P.L.
25 105-277), as amended, and any regulations promulgated pursuant to
26 such act.

27 2. As used in this section, the term "mastectomy" means the
28 removal of all or part of the breast for medically necessary

1 reasons, as determined by a physician licensed pursuant to
2 chapter 334.

3 3. The provisions of this section shall not apply to a
4 supplemental insurance policy, including a life care contract,
5 accident-only policy, specified disease policy, hospital policy
6 providing a fixed daily benefit only, Medicare supplement policy,
7 short-term major medical policy with a duration of less than one
8 year, or long-term care policy.

9 376.1210. 1. Each entity offering individual and group
10 health insurance policies providing coverage on an
11 expense-incurred basis, individual and group service or indemnity
12 type contracts issued by a nonprofit corporation, individual and
13 group service contracts issued by a health maintenance
14 organization, all self-insured group arrangements to the extent
15 not preempted by federal law, and all managed health care
16 delivery entities of any type or description, that are delivered,
17 issued for delivery, continued or renewed in this state on or
18 after January 1, 1997, and providing for maternity benefits,
19 shall provide coverage for a minimum of forty-eight hours of
20 inpatient care following a vaginal delivery and a minimum of
21 ninety-six hours of inpatient care following a cesarean section
22 for a mother and her newly born child in a hospital as defined in
23 section 197.020 or any other health care facility licensed to
24 provide obstetrical care under the provisions of chapter 197.

25 2. Notwithstanding the provisions of subsection 1 of this
26 section, any entity offering individual and group health
27 insurance policies providing coverage on an expense-incurred
28 basis, individual and group service or indemnity type contracts

1 issued by a nonprofit corporation, individual and group service
2 contracts issued by a health maintenance organization, all
3 self-insured group arrangements to the extent not preempted by
4 federal law, and all managed health care delivery entities of any
5 type or description that are delivered, issued for delivery,
6 continued or renewed in this state on or after January 1, 1997,
7 and providing for maternity benefits, may authorize a shorter
8 length of hospital stay for services related to maternity and
9 newborn care if:

10 (1) A shorter hospital stay meets with the approval of the
11 attending physician after consulting with the mother. The
12 physician's approval to discharge shall be made in accordance
13 with the most current version of the "Guidelines for Perinatal
14 Care" prepared by the American Academy of Pediatrics and the
15 American College of Obstetricians and Gynecologists, or similar
16 guidelines prepared by another nationally recognized medical
17 organization; and

18 (2) The entity providing the individual or group health
19 insurance policy provides coverage for post-discharge care to the
20 mother and her newborn.

21 3. Post-discharge care shall consist of a minimum of two
22 visits at least one of which shall be in the home, in accordance
23 with accepted maternal and neonatal physical assessments, by a
24 registered professional nurse with experience in maternal and
25 child health nursing or a physician. The location and schedule
26 of the post-discharge visits shall be determined by the attending
27 physician. Services provided by the registered professional
28 nurse or physician shall include, but not be limited to, physical

1 assessment of the newborn and mother, parent education,
2 assistance and training in breast or bottle feeding, education
3 and services for complete childhood immunizations, the
4 performance of any necessary and appropriate clinical tests and
5 submission of a metabolic specimen satisfactory to the state
6 laboratory. Such services shall be in accordance with the
7 medical criteria outlined in the most current version of the
8 "Guidelines for Perinatal Care" prepared by the American Academy
9 of Pediatrics and the American College of Obstetricians and
10 Gynecologists, or similar guidelines prepared by another
11 nationally recognized medical organization. Any abnormality, in
12 the condition of the mother or the child, observed by the nurse
13 shall be reported to the attending physician as medically
14 appropriate.

15 4. For the purposes of this section, "attending physician"
16 shall include the attending obstetrician, pediatrician, or other
17 physician attending the mother or newly born child.

18 5. Each entity offering individual and group health
19 insurance policies providing coverage on an expense-incurred
20 basis, individual and group service or indemnity type contracts
21 issued by a nonprofit corporation, individual and group service
22 contracts issued by a health maintenance organization, all
23 self-insured group arrangements to the extent not preempted by
24 federal law and all managed health care delivery entities of any
25 type or description shall provide notice to policyholders,
26 insured persons and participants regarding the coverage required
27 by this section. Such notice shall be in writing and prominently
28 positioned in the policy, certificate of coverage or summary plan

1 description.

2 6. Such health care service shall not be subject to any
3 greater deductible or co-payment than other similar health care
4 services provided by the policy, contract or plan.

5 7. No insurer may provide financial disincentives to, or
6 deselect, terminate the services of, require additional
7 documentation from, require additional utilization review, or
8 reduce payments to, or otherwise penalize the attending physician
9 in retaliation solely for ordering care consistent with the
10 provisions of this section.

11 8. The provisions of this section shall not apply to short-
12 term major medical policies with durations of less than one year.

13 9. The department of insurance, financial institutions and
14 professional registration shall adopt rules and regulations to
15 implement and enforce the provisions of this section. No rule or
16 portion of a rule promulgated pursuant to this section shall
17 become effective unless it has been promulgated pursuant to the
18 provisions of section 536.024.

19 376.1215. 1. All individual and group health insurance
20 policies providing coverage on an expense-incurred basis,
21 individual and group service or indemnity type contracts issued
22 by a health services corporation, individual and group service
23 contracts issued by a health maintenance organization and all
24 self-insured group arrangements to the extent not preempted by
25 federal law and all managed health care delivery entities of any
26 type or description shall provide coverage for immunizations of a
27 child from birth to five years of age as provided by department
28 of health and senior services regulations.

1 2. Such coverage shall not be subject to any deductible or
2 co-payment limits.

3 3. The contract issued by a health maintenance organization
4 may provide that the benefits required pursuant to this section
5 shall be covered benefits only if the services are rendered by a
6 provider who is designated by and affiliated with the health
7 maintenance organization, except that the health maintenance
8 organization shall, as a condition of participation, comply with
9 the immunization requirements of state or federally funded health
10 programs.

11 4. This section shall not apply to supplemental insurance
12 policies, including life care contracts, accident-only policies,
13 specified disease policies, hospital policies providing a fixed
14 daily benefit only, Medicare supplement policies, long-term care
15 policies, coverage issued as a supplement to liability insurance,
16 short-term major medical policies [of six months or less
17 duration] with durations of less than one year, and other
18 supplemental policies as determined by the department of
19 insurance, financial institutions and professional registration.

20 5. The department of health and senior services shall
21 promulgate rules and regulations to determine which immunizations
22 shall be covered by policies, plans or contracts described in
23 this section. No rule or portion of a rule promulgated under the
24 authority of this section shall become effective unless it has
25 been promulgated pursuant to the provisions of section 536.024.

26 6. No health care provider shall charge more than one
27 hundred percent of the reasonable and customary charges for
28 providing any immunization.

1 376.1218. 1. Any health carrier or health benefit plan
2 that offers or issues health benefit plans, other than Medicaid
3 health benefit plans, which are delivered, issued for delivery,
4 continued, or renewed in this state on or after January 1, 2006,
5 shall provide coverage for early intervention services described
6 in this section that are delivered by early intervention
7 specialists who are health care professionals licensed by the
8 state of Missouri and acting within the scope of their
9 professions for children from birth to age three identified by
10 the Part C early intervention system as eligible for services
11 under Part C of the Individuals with Disabilities Education Act,
12 20 U.S.C. Section 1431, et seq. Such coverage shall be limited
13 to three thousand dollars for each covered child per policy per
14 calendar year, with a maximum of nine thousand dollars per child.

15 2. As used in this section, "health carrier" and "health
16 benefit plan" shall have the same meaning as such terms are
17 defined in section 376.1350.

18 3. In the event that any health benefit plan is found not
19 to be required to provide coverage under subsection 1 of this
20 section because of preemption by a federal law, including but not
21 limited to the act commonly known as ERISA contained in Title 29
22 of the United States Code, or in the event that subsection 1 of
23 this section is found to be unconstitutional, then the lead
24 agency shall be responsible for payment and provision of any
25 benefit provided under this section.

26 4. For purposes of this section, "early intervention
27 services" means medically necessary speech and language therapy,
28 occupational therapy, physical therapy, and assistive technology

1 devices for children from birth to age three who are identified
2 by the Part C early intervention system as eligible for services
3 under Part C of the Individuals with Disabilities Education Act,
4 20 U.S.C. Section 1431, et seq. Early intervention services
5 shall include services under an active individualized family
6 service plan that enhance functional ability without effecting a
7 cure. An individualized family service plan is a written plan
8 for providing early intervention services to an eligible child
9 and the child's family that is adopted in accordance with 20
10 U.S.C. Section 1436. The Part C early intervention system, on
11 behalf of its contracted regional Part C early intervention
12 system centers and providers, shall be considered the rendering
13 provider of services for purposes of this section.

14 5. No payment made for specified early intervention
15 services shall be applied by the health carrier or health benefit
16 plan against any maximum lifetime aggregate specified in the
17 policy or health benefit plan if the carrier opts to satisfy its
18 obligations under this section under subdivision (2) of
19 subsection 7 of this section. A health benefit plan shall be
20 billed at the applicable Medicaid rate at the time the covered
21 benefit is delivered, and the health benefit plan shall pay the
22 Part C early intervention system at such rate for benefits
23 covered by this section. Services under the Part C early
24 intervention system shall be delivered as prescribed by the
25 individualized family service plan and an electronic claim filed
26 in accordance with the carrier's or plan's standard format.
27 Beginning January 1, 2007, such claims' payments shall be made in
28 accordance with the provisions of sections 376.383 and 376.384.

1 6. The health care service required by this section shall
2 not be subject to any greater deductible, co-payment, or
3 coinsurance than other similar health care services provided by
4 the health benefit plan.

5 7. (1) Subject to the provisions of this section, payments
6 made during a calendar year by a health carrier or group of
7 carriers affiliated by or under common ownership or control to
8 the Part C early intervention system for services provided to
9 children covered by the Part C early intervention system shall
10 not exceed one-half of one percent of the direct written premium
11 for health benefit plans as reported to the department of
12 insurance, financial institutions and professional registration
13 on the health carrier's most recently filed annual financial
14 statement.

15 (2) In lieu of reimbursing claims under this section, a
16 carrier or group of carriers affiliated by or under common
17 ownership or control may, on behalf of all of the carrier's or
18 carriers' health benefit plan or plans providing coverage under
19 this section, directly pay the Part C early intervention system
20 by January thirty-first of the calendar year an amount equal to
21 one-half of one percent of the direct written premium for health
22 benefit plans as reported to the department of insurance,
23 financial institutions and professional registration on the
24 health carrier's most recently filed annual financial statement,
25 or five hundred thousand dollars, whichever is less, and such
26 payment shall constitute full and complete satisfaction of the
27 health benefit plan's obligation for the calendar year. Nothing
28 in this subsection shall require a health carrier or health

1 benefit plan providing coverage under this section to amend or
2 modify any provision of an existing policy or plan relating to
3 the payment or reimbursement of claims by the health carrier or
4 health benefit plan.

5 8. This section shall not apply to a supplemental insurance
6 policy, including a life care contract, specified disease policy,
7 hospital policy providing a fixed daily benefit only, Medicare
8 supplement policy, hospitalization-surgical care policy, policy
9 that is individually underwritten or provides such coverage for
10 specific individuals and members of their families, long-term
11 care policy, or short-term major medical [policies of six months
12 or less] policy with a duration of less than one year.

13 9. Except for health carriers or health benefit plans
14 making payments under subdivision (2) of subsection 7 of this
15 section, the department of insurance, financial institutions and
16 professional registration shall collect data related to the
17 number of children receiving private insurance coverage under
18 this section and the total amount of moneys paid on behalf of
19 such children by private health carriers or health benefit plans.
20 The department shall report to the general assembly regarding the
21 department's findings no later than January 30, 2007, and
22 annually thereafter.

23 10. Notwithstanding the provisions of section 23.253 to the
24 contrary, the provisions of this section shall not sunset.

25 376.1219. 1. Each policy issued by an entity offering
26 individual and group health insurance which provides coverage on
27 an expense-incurred basis, individual and group health service or
28 indemnity type contracts issued by a nonprofit corporation,

1 individual and group service contracts issued by a health
2 maintenance organization, all self-insured group health
3 arrangements to the extent not preempted by federal law, and all
4 health care plans provided by managed health care delivery
5 entities of any type or description, that are delivered, issued
6 for delivery, continued or renewed in this state on or after
7 September 1, 1997, shall provide coverage for formula and low
8 protein modified food products recommended by a physician for the
9 treatment of a patient with phenylketonuria or any inherited
10 disease of amino and organic acids who is covered under the
11 policy, contract, or plan and who is less than six years of age.

12 2. For purposes of this section, "low protein modified food
13 products" means foods that are specifically formulated to have
14 less than one gram of protein per serving and are intended to be
15 used under the direction of a physician for the dietary treatment
16 of any inherited metabolic disease. Low protein modified food
17 products do not include foods that are naturally low in protein.

18 3. The coverage required by this section may be subject to
19 the same deductible for similar health care services provided by
20 the policy, contract, or plan as well as a reasonable coinsurance
21 or co-payment on the part of the insured, which shall not be
22 greater than fifty percent of the cost of the formula and food
23 products, and may be subject to an annual benefit maximum of not
24 less than five thousand dollars per covered child. Nothing in
25 this section shall prohibit a carrier from using individual case
26 management or from contracting with vendors of the formula and
27 food products.

28 4. This section shall not apply to a supplemental insurance

1 policy, including a life care contract, accident-only policy,
2 specified disease policy, hospital policy providing a fixed daily
3 benefit only, Medicare supplement policy, long-term care policy,
4 short-term major medical policy with a duration of less than one
5 year, or any other supplemental policy as determined by the
6 director of the department of insurance, financial institutions
7 and professional registration.

8 376.1220. 1. Each policy issued by an entity offering
9 individual and group health insurance which provides coverage on
10 an expense-incurred basis, individual or group health service, or
11 indemnity contracts issued by a nonprofit corporation, individual
12 and group service contracts issued by a health maintenance
13 organization, all self-insured group health arrangements to the
14 extent not preempted by federal law, and all health care plans
15 provided by managed health care delivery entities of any type or
16 description that are delivered, issued for delivery, continued or
17 renewed in this state shall provide coverage for newborn hearing
18 screening, necessary rescreening, audiological assessment and
19 follow-up, and initial amplification.

20 2. The health care service required by this section shall
21 not be subject to any greater deductible or co-payment than other
22 similar health care services provided by the policy, contract or
23 plan.

24 3. This section shall not apply to a supplemental insurance
25 policy, including a life care contract, accident-only policy,
26 specified disease policy, hospital policy providing a fixed daily
27 benefit only, Medicare supplement policy, long-term care policy,
28 short-term major medical [policies of six months or less] policy

1 with a duration of less than one year, or any other supplemental
2 policy as determined by the director of the department of
3 insurance, financial institutions and professional registration.

4 4. Coverage for newborn hearing screening and any necessary
5 rescreening and audiological assessment shall be provided to
6 newborns eligible for medical assistance pursuant to section
7 208.151, and the children's health program pursuant to sections
8 208.631 to 208.660, with payment for the newborn hearing
9 screening required in section 191.925, and any necessary
10 rescreening, audiological assessment and follow-up, and
11 amplification as described in section 191.928.

12 376.1224. 1. For purposes of this section, the following
13 terms shall mean:

14 (1) "Applied behavior analysis", the design,
15 implementation, and evaluation of environmental modifications,
16 using behavioral stimuli and consequences, to produce socially
17 significant improvement in human behavior, including the use of
18 direct observation, measurement, and functional analysis of the
19 relationships between environment and behavior;

20 (2) "Autism service provider":

21 (a) Any person, entity, or group that provides diagnostic
22 or treatment services for autism spectrum disorders who is
23 licensed or certified by the state of Missouri; or

24 (b) Any person who is licensed under chapter 337 as a
25 board-certified behavior analyst by the behavior analyst
26 certification board or licensed under chapter 337 as an assistant
27 board-certified behavior analyst;

28 (3) "Autism spectrum disorders", a neurobiological

1 disorder, an illness of the nervous system, which includes
2 Autistic Disorder, Asperger's Disorder, Pervasive Developmental
3 Disorder Not Otherwise Specified, Rett's Disorder, and Childhood
4 Disintegrative Disorder, as defined in the most recent edition of
5 the Diagnostic and Statistical Manual of Mental Disorders of the
6 American Psychiatric Association;

7 (4) "Diagnosis of autism spectrum disorders", medically
8 necessary assessments, evaluations, or tests in order to diagnose
9 whether an individual has an autism spectrum disorder;

10 (5) "Habilitative or rehabilitative care", professional,
11 counseling, and guidance services and treatment programs,
12 including applied behavior analysis, that are necessary to
13 develop the functioning of an individual;

14 (6) "Health benefit plan", shall have the same meaning
15 ascribed to it as in section 376.1350;

16 (7) "Health carrier", shall have the same meaning ascribed
17 to it as in section 376.1350;

18 (8) "Line therapist", an individual who provides
19 supervision of an individual diagnosed with an autism diagnosis
20 and other neurodevelopmental disorders pursuant to the prescribed
21 treatment plan, and implements specific behavioral interventions
22 as outlined in the behavior plan under the direct supervision of
23 a licensed behavior analyst;

24 (9) "Pharmacy care", medications used to address symptoms
25 of an autism spectrum disorder prescribed by a licensed
26 physician, and any health-related services deemed medically
27 necessary to determine the need or effectiveness of the
28 medications only to the extent that such medications are included

1 in the insured's health benefit plan;

2 (10) "Psychiatric care", direct or consultative services
3 provided by a psychiatrist licensed in the state in which the
4 psychiatrist practices;

5 (11) "Psychological care", direct or consultative services
6 provided by a psychologist licensed in the state in which the
7 psychologist practices;

8 (12) "Therapeutic care", services provided by licensed
9 speech therapists, occupational therapists, or physical
10 therapists;

11 (13) "Treatment for autism spectrum disorders", care
12 prescribed or ordered for an individual diagnosed with an autism
13 spectrum disorder by a licensed physician or licensed
14 psychologist, including equipment medically necessary for such
15 care, pursuant to the powers granted under such licensed
16 physician's or licensed psychologist's license, including, but
17 not limited to:

18 (a) Psychiatric care;

19 (b) Psychological care;

20 (c) Habilitative or rehabilitative care, including applied
21 behavior analysis therapy;

22 (d) Therapeutic care;

23 (e) Pharmacy care.

24 2. All group health benefit plans that are delivered,
25 issued for delivery, continued, or renewed on or after January 1,
26 2011, if written inside the state of Missouri, or written outside
27 the state of Missouri but insuring Missouri residents, shall
28 provide coverage for the diagnosis and treatment of autism

1 spectrum disorders to the extent that such diagnosis and
2 treatment is not already covered by the health benefit plan.

3 3. With regards to a health benefit plan, a health carrier
4 shall not deny or refuse to issue coverage on, refuse to contract
5 with, or refuse to renew or refuse to reissue or otherwise
6 terminate or restrict coverage on an individual or their
7 dependent because the individual is diagnosed with autism
8 spectrum disorder.

9 4. (1) Coverage provided under this section is limited to
10 medically necessary treatment that is ordered by the insured's
11 treating licensed physician or licensed psychologist, pursuant to
12 the powers granted under such licensed physician's or licensed
13 psychologist's license, in accordance with a treatment plan.

14 (2) The treatment plan, upon request by the health benefit
15 plan or health carrier, shall include all elements necessary for
16 the health benefit plan or health carrier to pay claims. Such
17 elements include, but are not limited to, a diagnosis, proposed
18 treatment by type, frequency and duration of treatment, and
19 goals.

20 (3) Except for inpatient services, if an individual is
21 receiving treatment for an autism spectrum disorder, a health
22 carrier shall have the right to review the treatment plan not
23 more than once every six months unless the health carrier and the
24 individual's treating physician or psychologist agree that a more
25 frequent review is necessary. Any such agreement regarding the
26 right to review a treatment plan more frequently shall only apply
27 to a particular individual being treated for an autism spectrum
28 disorder and shall not apply to all individuals being treated for

1 autism spectrum disorders by a physician or psychologist. The
2 cost of obtaining any review or treatment plan shall be borne by
3 the health benefit plan or health carrier, as applicable.

4 5. Coverage provided under this section for applied
5 behavior analysis shall be subject to a maximum benefit of forty
6 thousand dollars per calendar year for individuals through
7 eighteen years of age. Such maximum benefit limit may be
8 exceeded, upon prior approval by the health benefit plan, if the
9 provision of applied behavior analysis services beyond the
10 maximum limit is medically necessary for such individual.

11 Payments made by a health carrier on behalf of a covered
12 individual for any care, treatment, intervention, service or
13 item, the provision of which was for the treatment of a health
14 condition unrelated to the covered individual's autism spectrum
15 disorder, shall not be applied toward any maximum benefit
16 established under this subsection. Any coverage required under
17 this section, other than the coverage for applied behavior
18 analysis, shall not be subject to the age and dollar limitations
19 described in this subsection.

20 6. The maximum benefit limitation for applied behavior
21 analysis described in subsection 5 of this section shall be
22 adjusted by the health carrier at least triennially for inflation
23 to reflect the aggregate increase in the general price level as
24 measured by the Consumer Price Index for All Urban Consumers for
25 the United States, or its successor index, as defined and
26 officially published by the United States Department of Labor, or
27 its successor agency. Beginning January 1, 2012, and annually
28 thereafter, the current value of the maximum benefit limitation

1 for applied behavior analysis coverage adjusted for inflation in
2 accordance with this subsection shall be calculated by the
3 director of the department of insurance, financial institutions
4 and professional registration. The director shall furnish the
5 calculated value to the secretary of state, who shall publish
6 such value in the Missouri Register as soon after each January
7 first as practicable, but it shall otherwise be exempt from the
8 provisions of section 536.021.

9 7. Subject to the provisions set forth in subdivision (3)
10 of subsection 4 of this section, coverage provided under this
11 section shall not be subject to any limits on the number of
12 visits an individual may make to an autism service provider,
13 except that the maximum total benefit for applied behavior
14 analysis set forth in subsection 5 of this section shall apply to
15 this subsection.

16 8. This section shall not be construed as limiting benefits
17 which are otherwise available to an individual under a health
18 benefit plan. The health care coverage required by this section
19 shall not be subject to any greater deductible, coinsurance, or
20 co-payment than other physical health care services provided by a
21 health benefit plan. Coverage of services may be subject to
22 other general exclusions and limitations of the contract or
23 benefit plan, not in conflict with the provisions of this
24 section, such as coordination of benefits, exclusions for
25 services provided by family or household members, and utilization
26 review of health care services, including review of medical
27 necessity and care management; however, coverage for treatment
28 under this section shall not be denied on the basis that it is

1 educational or habilitative in nature.

2 9. To the extent any payments or reimbursements are being
3 made for applied behavior analysis, such payments or
4 reimbursements shall be made to either:

5 (1) The autism service provider, as defined in this
6 section; or

7 (2) The entity or group for whom such supervising person,
8 who is certified as a board-certified behavior analyst by the
9 Behavior Analyst Certification Board, works or is associated.

10
11 Such payments or reimbursements under this subsection to an
12 autism service provider or a board-certified behavior analyst
13 shall include payments or reimbursements for services provided by
14 a line therapist under the supervision of such provider or
15 behavior analyst if such services provided by the line therapist
16 are included in the treatment plan and are deemed medically
17 necessary.

18 10. Notwithstanding any other provision of law to the
19 contrary, health carriers shall not be held liable for the
20 actions of line therapists in the performance of their duties.

21 11. The provisions of this section shall apply to any
22 health care plans issued to employees and their dependents under
23 the Missouri consolidated health care plan established pursuant
24 to chapter 103 that are delivered, issued for delivery,
25 continued, or renewed in this state on or after January 1, 2011.
26 The terms "employees" and "health care plans" shall have the same
27 meaning ascribed to them in section 103.003.

28 12. The provisions of this section shall also apply to the

1 following types of plans that are established, extended,
2 modified, or renewed on or after January 1, 2011:

3 (1) All self-insured governmental plans, as that term is
4 defined in 29 U.S.C. Section 1002(32);

5 (2) All self-insured group arrangements, to the extent not
6 preempted by federal law;

7 (3) All plans provided through a multiple employer welfare
8 arrangement, or plans provided through another benefit
9 arrangement, to the extent permitted by the Employee Retirement
10 Income Security Act of 1974, or any waiver or exception to that
11 act provided under federal law or regulation; and

12 (4) All self-insured school district health plans.

13 13. The provisions of this section shall not automatically
14 apply to an individually underwritten health benefit plan, but
15 shall be offered as an option to any such plan.

16 14. The provisions of this section shall not apply to a
17 supplemental insurance policy, including a life care contract,
18 accident-only policy, specified disease policy, hospital policy
19 providing a fixed daily benefit only, Medicare supplement policy,
20 long-term care policy, short-term major medical policy [of six
21 months or less] with a duration of less than one year, or any
22 other supplemental policy.

23 15. Any health carrier or other entity subject to the
24 provisions of this section shall not be required to provide
25 reimbursement for the applied behavior analysis delivered to a
26 person insured by such health carrier or other entity to the
27 extent such health carrier or other entity is billed for such
28 services by any Part C early intervention program or any school

1 district for applied behavior analysis rendered to the person
2 covered by such health carrier or other entity. This section
3 shall not be construed as affecting any obligation to provide
4 services to an individual under an individualized family service
5 plan, an individualized education plan, or an individualized
6 service plan. This section shall not be construed as affecting
7 any obligation to provide reimbursement pursuant to section
8 376.1218.

9 16. The provisions of sections 376.383, 376.384, and
10 376.1350 to 376.1399 shall apply to this section.

11 17. The director of the department of insurance, financial
12 institutions and professional registration shall grant a small
13 employer with a group health plan, as that term is defined in
14 section 379.930, a waiver from the provisions of this section if
15 the small employer demonstrates to the director by actual claims
16 experience over any consecutive twelve-month period that
17 compliance with this section has increased the cost of the health
18 insurance policy by an amount of two and a half percent or
19 greater over the period of a calendar year in premium costs to
20 the small employer.

21 18. The provisions of this section shall not apply to the
22 Mo HealthNet program as described in chapter 208.

23 19. (1) By February 1, 2012, and every February first
24 thereafter, the department of insurance, financial institutions
25 and professional registration shall submit a report to the
26 general assembly regarding the implementation of the coverage
27 required under this section. The report shall include, but shall
28 not be limited to, the following:

1 (a) The total number of insureds diagnosed with autism
2 spectrum disorder;

3 (b) The total cost of all claims paid out in the
4 immediately preceding calendar year for coverage required by this
5 section;

6 (c) The cost of such coverage per insured per month; and

7 (d) The average cost per insured for coverage of applied
8 behavior analysis;

9 (2) All health carriers and health benefit plans subject to
10 the provisions of this section shall provide the department with
11 the data requested by the department for inclusion in the annual
12 report.

13 376.1225. 1. All individual and group health insurance
14 policies providing coverage on an expense-incurred basis,
15 individual and group service or indemnity type contracts issued
16 by a nonprofit corporation, individual and group service
17 contracts issued by a health maintenance organization, all
18 self-insured group arrangements to the extent not preempted by
19 federal law and all managed health care delivery entities of any
20 type or description, that are delivered, issued for delivery,
21 continued or renewed on or after August 28, 1998, shall provide
22 coverage for administration of general anesthesia and hospital
23 charges for dental care provided to the following covered
24 persons:

25 (1) A child under the age of five;

26 (2) A person who is severely disabled; or

27 (3) A person who has a medical or behavioral condition
28 which requires hospitalization or general anesthesia when dental

1 care is provided.

2 2. Each plan as described in this section must provide
3 coverage for administration of general anesthesia and hospital or
4 office charges for treatment rendered by a dentist, regardless of
5 whether the services are provided in a participating hospital or
6 surgical center or office.

7 3. Nothing in this section shall prevent a health carrier
8 from requiring prior authorization for hospitalization for dental
9 care procedures in the same manner that prior authorization is
10 required for hospitalization for other covered diseases or
11 conditions.

12 4. Nothing in this section shall apply to accident-only,
13 dental-only plans or other specified disease, hospital indemnity,
14 Medicare supplement or long-term care policies, or short-term
15 major medical policies [of six months or less in duration] with
16 durations of less than one year.

17 376.1230. 1. Every policy issued by a health carrier, as
18 defined in section 376.1350, shall provide coverage for
19 chiropractic care delivered by a licensed chiropractor acting
20 within the scope of his or her practice as defined in chapter
21 331. The coverage shall include initial diagnosis and clinically
22 appropriate and medically necessary services and supplies
23 required to treat the diagnosed disorder, subject to the terms
24 and conditions of the policy. The coverage may be limited to
25 chiropractors within the health carrier's network, and nothing in
26 this section shall be construed to require a health carrier to
27 contract with a chiropractor not in the carrier's network nor
28 shall a carrier be required to reimburse for services rendered by

1 a nonnetwork chiropractor unless prior approval has been obtained
2 from the carrier by the enrollee. An enrollee may access
3 chiropractic care within the network for a total of twenty-six
4 chiropractic physician office visits per policy period, but may
5 be required to provide the health carrier with notice prior to
6 any additional visit as a condition of coverage. A health
7 carrier may require prior authorization or notification before
8 any follow-up diagnostic tests are ordered by a chiropractor or
9 for any office visits for treatment in excess of twenty-six in
10 any policy period. The certificate of coverage for any health
11 benefit plan issued by a health carrier shall clearly state the
12 availability of chiropractic coverage under the policy and any
13 limitations, conditions, and exclusions.

14 2. A health benefit plan shall provide coverage for
15 treatment of a chiropractic care condition and shall not
16 establish any rate, term, or condition that places a greater
17 financial burden on an insured for access to treatment for a
18 chiropractic care condition than for access to treatment for
19 another physical health condition.

20 3. The provisions of this section shall not apply to any
21 health plan or contract that is individually underwritten.

22 4. The provisions of this section shall not apply to
23 benefits provided under the Medicaid program.

24 5. The provisions of this section shall not apply to a
25 supplemental insurance policy, including a life care contract,
26 accident-only policy, specified disease policy, hospital policy
27 providing a fixed daily benefit only, Medicare supplement policy,
28 long-term care policy, short-term major medical policy [of six

1 months' or less] with a duration of less than one year, or any
2 other similar supplemental policy.

3 376.1232. 1. Each health carrier or health benefit plan
4 that offers or issues health benefit plans which are delivered,
5 issued for delivery, continued, or renewed in this state on or
6 after January 1, 2010, shall offer coverage for prosthetic
7 devices and services, including original and replacement devices,
8 as prescribed by a physician acting within the scope of his or
9 her practice.

10 2. For the purposes of this section, "health carrier" and
11 "health benefit plan" shall have the same meaning as defined in
12 section 376.1350.

13 3. The amount of the benefit for prosthetic devices and
14 services under this section shall be no less than the annual and
15 lifetime benefit maximums applicable to the basic health care
16 services required to be provided under the health benefit plan.
17 If the health benefit plan does not include any annual or
18 lifetime maximums applicable to basic health care services, the
19 amount of the benefit for prosthetic devices and services shall
20 not be subject to an annual or lifetime maximum benefit level.
21 Any co-payment, coinsurance, deductible, and maximum
22 out-of-pocket amount applied to the benefit for prosthetic
23 devices and services shall be no more than the most common
24 amounts applied to the basic health care services required to be
25 provided under the health benefit plan.

26 4. The provisions of this section shall not apply to a
27 supplemental insurance policy, including a life care contract,
28 accident-only policy, specified disease policy, hospital policy

1 providing a fixed daily benefit only, Medicare supplement policy,
2 long-term care policy, short-term major medical [policies of six
3 months or less] policy with a duration of less than one year, or
4 any other supplemental policy as determined by the director of
5 the department of insurance, financial institutions and
6 professional registration.

7 376.1235. 1. No health carrier or health benefit plan, as
8 defined in section 376.1350, shall impose a co-payment or
9 coinsurance percentage charged to the insured for services
10 rendered for each date of service by a physical therapist
11 licensed under chapter 334 or an occupational therapist licensed
12 under chapter 324, for services that require a prescription, that
13 is greater than the co-payment or coinsurance percentage charged
14 to the insured for the services of a primary care physician
15 licensed under chapter 334 for an office visit.

16 2. A health carrier or health benefit plan shall clearly
17 state the availability of physical therapy and occupational
18 therapy coverage under its plan and all related limitations,
19 conditions, and exclusions.

20 3. The provisions of subsections 1 and 2 of this section
21 shall not apply to short-term major medical policies with
22 durations of less than one year.

23 4. Beginning September 1, 2016, the oversight division of
24 the joint committee on legislative research shall perform an
25 actuarial analysis of the cost impact to health carriers,
26 insureds with a health benefit plan, and other private and public
27 payers if the provisions of this section regarding occupational
28 therapy coverage were enacted. By December 31, 2016, the

1 director of the oversight division of the joint committee on
2 legislative research shall submit a report of the actuarial
3 findings prescribed by this section to the speaker, the president
4 pro tem, and the chairpersons of both the house of
5 representatives and senate standing committees having
6 jurisdiction over health insurance matters. If the fiscal note
7 cost estimation is less than the cost of an actuarial analysis,
8 the actuarial analysis requirement shall be waived.

9 376.1250. 1. All individual and group health insurance
10 policies providing coverage on an expense-incurred basis,
11 individual and group service or indemnity type contracts issued
12 by a nonprofit corporation, individual and group service
13 contracts issued by a health maintenance organization, all
14 self-insured group arrangements to the extent not preempted by
15 federal law and all managed health care delivery entities of any
16 type or description, that are delivered, issued for delivery,
17 continued or renewed on or after August 28, 1999, and providing
18 coverage to any resident of this state shall provide benefits or
19 coverage for:

20 (1) A pelvic examination and pap smear for any
21 nonsymptomatic woman covered under such policy or contract, in
22 accordance with the current American Cancer Society guidelines;

23 (2) A prostate examination and laboratory tests for cancer
24 for any nonsymptomatic man covered under such policy or contract,
25 in accordance with the current American Cancer Society
26 guidelines; and

27 (3) A colorectal cancer examination and laboratory tests
28 for cancer for any nonsymptomatic person covered under such

1 policy or contract, in accordance with the current American
2 Cancer Society guidelines.

3 2. Coverage and benefits related to the examinations and
4 tests as required by this section shall be at least as favorable
5 and subject to the same dollar limits, deductible, and
6 co-payments as other covered benefits or services.

7 3. Nothing in this act shall apply to accident-only,
8 hospital indemnity, Medicare supplement, long-term care, or other
9 limited benefit health insurance policies.

10 4. The provisions of this section shall not apply to
11 short-term major medical policies [of six months or less
12 duration] with durations of less than one year.

13 5. The attending physician shall advise the patient of the
14 advantages, disadvantages, and risks, including cancer,
15 associated with breast implantation prior to such operation.

16 6. Nothing in this section shall alter, impair or otherwise
17 affect claims, rights or remedies available pursuant to law.

18 376.1253. 1. Each physician attending any patient with a
19 newly diagnosed cancer shall inform the patient that the patient
20 has the right to a referral for a second opinion by an
21 appropriate board-certified specialist prior to any treatment.
22 If no specialist in that specific cancer diagnosis area is in the
23 provider network, a referral shall be made to a nonnetwork
24 specialist in accordance with this section.

25 2. Each health carrier or health benefit plan, as defined
26 in section 376.1350, that offers or issues health benefit plans
27 which are delivered, issued for delivery, continued or renewed in
28 this state on or after January 1, 2003, shall provide coverage

1 for a second opinion rendered by a specialist in that specific
2 cancer diagnosis area when a patient with a newly diagnosed
3 cancer is referred to such specialist by his or her attending
4 physician. Such coverage shall be subject to the same deductible
5 and coinsurance conditions applied to other specialist referrals
6 and all other terms and conditions applicable to other benefits,
7 including the prior authorization and/or referral authorization
8 requirements as specified in the applicable health insurance
9 policy.

10 3. The provisions of this section shall not apply to a
11 supplemental insurance policy, including a life care contract,
12 accident-only policy, specified disease policy, hospital policy
13 providing a fixed daily benefit only, Medicare supplement policy,
14 long-term care policy, short-term major medical [policies of six
15 months' or less] policy with a duration of less than one year, or
16 any other supplemental policy as determined by the director of
17 the department of insurance, financial institutions and
18 professional registration.

19 376.1257. 1. As used in this section the following terms
20 shall mean:

21 (1) "Anticancer medications", medications used to kill or
22 slow the growth of cancerous cells;

23 (2) "Covered person", a policyholder, subscriber, enrollee,
24 or other individual enrolled in or insured by a health benefit
25 plan for health insurance coverage;

26 (3) "Health benefit plan", shall have the same meaning as
27 defined in section 376.1350.

28 2. Any health benefit plan that provides coverage and

1 benefits for cancer treatment shall provide coverage of
2 prescribed orally administered anticancer medications on a basis
3 no less favorable than intravenously administered or injected
4 anticancer medications.

5 3. Coverage of orally administered anticancer medication
6 shall not be subject to any prior authorization, dollar limit,
7 co-payment, deductible, or other out-of-pocket expense that does
8 not apply to intravenously administered or injected anticancer
9 medication, regardless of formulation or benefit category
10 determination by the company administering the health benefit
11 plan.

12 4. The health benefit plan shall not reclassify or increase
13 any type of cost-sharing to the covered person for anticancer
14 medications in order to achieve compliance with this section.
15 Any change in health insurance coverage, which otherwise
16 increases an out-of-pocket expense to anticancer medications,
17 shall be applied to the majority of comparable medical or
18 pharmaceutical benefits covered by the health benefit plan.

19 5. Notwithstanding the provisions of subsections 2, 3, and
20 4 of this section, a health benefit plan that limits the total
21 amounts paid by a covered person through all cost-sharing
22 requirements to no more than seventy-five dollars per thirty-day
23 supply for any orally administered anticancer medication shall be
24 considered in compliance with this section. On January 1, 2016,
25 and on January first of each year thereafter, a health benefit
26 plan may adjust such seventy-five dollar limit. The adjustment
27 shall not exceed the Consumer Price Index for All Urban Consumers
28 Midwest Region for that year. For purposes of this subsection

1 "cost-sharing requirements" shall include co-payments,
2 coinsurance, deductibles, and any other amounts paid by the
3 covered person for that prescription.

4 6. For a health benefit plan that meets the definition of
5 "high deductible health plan" as defined by 26 U.S.C. 223(c)(2),
6 the provisions of subsection 5 of this section shall only apply
7 after a covered person's deductible has been satisfied for the
8 year.

9 7. The provisions of this section shall not apply to short-
10 term major medical policies with durations of less than one year.

11 8. The provisions of this section shall become effective
12 January 1, 2015.

13 376.1275. 1. Each health carrier or health benefit plan
14 that offers or issues health benefit plans which are delivered,
15 issued for delivery, continued, or renewed in this state on or
16 after January 1, 2003, shall include coverage for their members
17 for the cost for human leukocyte antigen testing, also referred
18 to as histocompatibility locus antigen testing, for A, B, and DR
19 antigens for utilization in bone marrow transplantation. The
20 testing must be performed in a facility which is accredited by
21 the American Association of Blood Banks or its successors, and is
22 licensed under the Clinical Laboratory Improvement Act, 42 U.S.C.
23 Section 263a, as amended, and is accredited by the American
24 Association of Blood Banks or its successors, the College of
25 American Pathologists, the American Society for
26 Histocompatibility and Immunogenetics (ASHI) or any other
27 national accrediting body with requirements that are
28 substantially equivalent to or more stringent than those of the

1 College of American Pathologists. At the time of testing, the
2 person being tested must complete and sign an informed consent
3 form which also authorizes the results of the test to be used for
4 participation in the National Marrow Donor Program. The health
5 benefit plan may limit each enrollee to one such testing per
6 lifetime to be reimbursed at a cost of no greater than
7 seventy-five dollars by the health carrier or health benefit
8 plan.

9 2. For the purposes of this section, "health carrier" and
10 "health benefit plan" shall have the same meaning as defined in
11 section 376.1350.

12 3. The health care service required by this section shall
13 not be subject to any greater deductible or co-payment than other
14 similar health care services provided by the health benefit plan.

15 4. The provisions of this section shall not apply to a
16 supplemental insurance policy, including a life care contract,
17 accident-only policy, specified disease policy, hospital policy
18 providing a fixed daily benefit only, Medicare supplement policy,
19 long-term care policy, short-term major medical [policies of six
20 months' or less] policy with a duration of less than one year, or
21 any other supplemental policy as determined by the director of
22 the department of insurance, financial institutions and
23 professional registration.

24 376.1290. 1. Each entity offering individual and group
25 health insurance policies providing coverage on an
26 expense-incurred basis, individual and group service or indemnity
27 type contracts issued by a health services corporation,
28 individual and group service contracts issued by a health

1 maintenance organization, all self-insured group arrangements, to
2 the extent not preempted by federal law, and all managed health
3 care delivery entities of any type or description that are
4 delivered, issued for delivery, continued or renewed in this
5 state on or after January 1, 2002, shall offer coverage for
6 testing pregnant women for lead poisoning and for all testing for
7 lead poisoning authorized by sections 701.340 to 701.349 or by
8 rule of the department of health and senior services promulgated
9 pursuant to sections 701.340 to 701.349.

10 2. Health care services required by this section shall not
11 be subject to any greater deductible or co-payment than any other
12 health care service provided by the policy, contract or plan.

13 3. No entity enumerated in subsection 1 of this section
14 shall reduce or eliminate coverage as a result of the
15 requirements of this section.

16 4. Nothing in this section shall apply to short-term major
17 medical policies with durations of one year or less, or to
18 accident-only, specified disease, hospital indemnity, Medicare
19 supplement, long-term care or other limited benefit health
20 insurance policies.

21 376.1550. 1. Notwithstanding any other provision of law to
22 the contrary, each health carrier that offers or issues health
23 benefit plans which are delivered, issued for delivery,
24 continued, or renewed in this state on or after January 1, 2005,
25 shall provide coverage for a mental health condition, as defined
26 in this section, and shall comply with the following provisions:

27 (1) A health benefit plan shall provide coverage for
28 treatment of a mental health condition and shall not establish

1 any rate, term, or condition that places a greater financial
2 burden on an insured for access to treatment for a mental health
3 condition than for access to treatment for a physical health
4 condition. Any deductible or out-of-pocket limits required by a
5 health carrier or health benefit plan shall be comprehensive for
6 coverage of all health conditions, whether mental or physical;

7 (2) The coverages set forth ~~[is]~~ in this subsection:

8 (a) May be administered pursuant to a managed care program
9 established by the health carrier; and

10 (b) May deliver covered services through a system of
11 contractual arrangements with one or more providers, hospitals,
12 nonresidential or residential treatment programs, or other mental
13 health service delivery entities certified by the department of
14 mental health, or accredited by a nationally recognized
15 organization, or licensed by the state of Missouri;

16 (3) A health benefit plan that does not otherwise provide
17 for management of care under the plan or that does not provide
18 for the same degree of management of care for all health
19 conditions may provide coverage for treatment of mental health
20 conditions through a managed care organization; provided that the
21 managed care organization is in compliance with rules adopted by
22 the department of insurance, financial institutions and
23 professional registration that assure that the system for
24 delivery of treatment for mental health conditions does not
25 diminish or negate the purpose of this section. The rules
26 adopted by the director shall assure that:

27 (a) Timely and appropriate access to care is available;

28 (b) The quantity, location, and specialty distribution of

1 health care providers is adequate; and

2 (c) Administrative or clinical protocols do not serve to
3 reduce access to medically necessary treatment for any insured;

4 (4) Coverage for treatment for chemical dependency shall
5 comply with sections 376.779, 376.810 to 376.814, and 376.825 to
6 376.836 and for the purposes of this subdivision the term "health
7 insurance policy" as used in sections 376.779, 376.810 to
8 376.814, and 376.825 to 376.836[, the term "health insurance
9 policy"] shall include group coverage.

10 2. As used in this section, the following terms mean:

11 (1) "Chemical dependency", the psychological or
12 physiological dependence upon and abuse of drugs, including
13 alcohol, characterized by drug tolerance or withdrawal and
14 impairment of social or occupational role functioning or both;

15 (2) "Health benefit plan", the same meaning as such term is
16 defined in section 376.1350;

17 (3) "Health carrier", the same meaning as such term is
18 defined in section 376.1350;

19 (4) "Mental health condition", any condition or disorder
20 defined by categories listed in the most recent edition of the
21 Diagnostic and Statistical Manual of Mental Disorders except for
22 chemical dependency;

23 (5) "Managed care organization", any financing mechanism or
24 system that manages care delivery for its members or subscribers,
25 including health maintenance organizations and any other similar
26 health care delivery system or organization;

27 (6) "Rate, term, or condition", any lifetime or annual
28 payment limits, deductibles, co-payments, coinsurance, and other

1 cost-sharing requirements, out-of-pocket limits, visit limits,
2 and any other financial component of a health benefit plan that
3 affects the insured.

4 3. This section shall not apply to a health plan or policy
5 that is individually underwritten or provides such coverage for
6 specific individuals and members of their families pursuant to
7 section 376.779, sections 376.810 to 376.814, and sections
8 376.825 to 376.836, a supplemental insurance policy, including a
9 life care contract, accident-only policy, specified disease
10 policy, hospital policy providing a fixed daily benefit only,
11 Medicare supplement policy, long-term care policy,
12 hospitalization-surgical care policy, short-term major medical
13 [policies of six months or less] policy with a duration of less
14 than one year, or any other supplemental policy as determined by
15 the director of the department of insurance, financial
16 institutions and professional registration.

17 4. Notwithstanding any other provision of law to the
18 contrary, all health insurance policies that cover state
19 employees, including the Missouri consolidated health care plan,
20 shall include coverage for mental illness. Multiyear group
21 policies need not comply until the expiration of their current
22 multiyear term unless the policyholder elects to comply before
23 that time.

24 5. The provisions of this section shall not be violated if
25 the insurer decides to apply different limits or exclude entirely
26 from coverage the following:

27 (1) Marital, family, educational, or training services
28 unless medically necessary and clinically appropriate;

1 (2) Services rendered or billed by a school or halfway
2 house;

3 (3) Care that is custodial in nature;

4 (4) Services and supplies that are not immediately nor
5 clinically appropriate; or

6 (5) Treatments that are considered experimental.

7 6. The director shall grant a policyholder a waiver from
8 the provisions of this section if the policyholder demonstrates
9 to the director by actual experience over any consecutive
10 twenty-four-month period that compliance with this section has
11 increased the cost of the health insurance policy by an amount
12 that results in a two percent increase in premium costs to the
13 policyholder. The director shall promulgate rules establishing a
14 procedure and appropriate standards for making such a
15 demonstration. Any rule or portion of a rule, as that term is
16 defined in section 536.010, that is created under the authority
17 delegated in this section shall become effective only if it
18 complies with and is subject to all of the provisions of chapter
19 536 and, if applicable, section 536.028. This section and
20 chapter 536 are nonseverable and if any of the powers vested with
21 the general assembly pursuant to chapter 536 to review, to delay
22 the effective date, or to disapprove and annul a rule are
23 subsequently held unconstitutional, then the grant of rulemaking
24 authority and any rule proposed or adopted after August 28, 2004,
25 shall be invalid and void.

26 376.1900. 1. As used in this section, the following terms
27 shall mean:

28 (1) "Electronic visit", or "e-visit", an online electronic

1 medical evaluation and management service completed using a
2 secured web-based or similar electronic-based communications
3 network for a single patient encounter. An electronic visit
4 shall be initiated by a patient or by the guardian of a patient
5 with the health care provider, be completed using a federal
6 Health Insurance Portability and Accountability Act
7 (HIPAA)-compliant online connection, and include a permanent
8 record of the electronic visit;

9 (2) "Health benefit plan" shall have the same meaning
10 ascribed to it in section 376.1350;

11 (3) "Health care provider" shall have the same meaning
12 ascribed to it in section 376.1350;

13 (4) "Health care service", a service for the diagnosis,
14 prevention, treatment, cure or relief of a physical or mental
15 health condition, illness, injury or disease;

16 (5) "Health carrier" shall have the same meaning ascribed
17 to it in section 376.1350;

18 (6) "Telehealth" shall have the same meaning ascribed to it
19 in section 208.670.

20 2. Each health carrier or health benefit plan that offers
21 or issues health benefit plans which are delivered, issued for
22 delivery, continued, or renewed in this state on or after January
23 1, 2014, shall not deny coverage for a health care service on the
24 basis that the health care service is provided through telehealth
25 if the same service would be covered if provided through
26 face-to-face diagnosis, consultation, or treatment.

27 3. A health carrier may not exclude an otherwise covered
28 health care service from coverage solely because the service is

1 provided through telehealth rather than face-to-face consultation
2 or contact between a health care provider and a patient.

3 4. A health carrier shall not be required to reimburse a
4 telehealth provider or a consulting provider for site origination
5 fees or costs for the provision of telehealth services; however,
6 subject to correct coding, a health carrier shall reimburse a
7 health care provider for the diagnosis, consultation, or
8 treatment of an insured or enrollee when the health care service
9 is delivered through telehealth on the same basis that the health
10 carrier covers the service when it is delivered in person.

11 5. A health care service provided through telehealth shall
12 not be subject to any greater deductible, co-payment, or
13 coinsurance amount than would be applicable if the same health
14 care service was provided through face-to-face diagnosis,
15 consultation, or treatment.

16 6. A health carrier shall not impose upon any person
17 receiving benefits under this section any co-payment,
18 coinsurance, or deductible amount, or any policy year, calendar
19 year, lifetime, or other durational benefit limitation or maximum
20 for benefits or services that is not equally imposed upon all
21 terms and services covered under the policy, contract, or health
22 benefit plan.

23 7. Nothing in this section shall preclude a health carrier
24 from undertaking utilization review to determine the
25 appropriateness of telehealth as a means of delivering a health
26 care service, provided that the determinations shall be made in
27 the same manner as those regarding the same service when it is
28 delivered in person.

1 8. A health carrier or health benefit plan may limit
2 coverage for health care services that are provided through
3 telehealth to health care providers that are in a network
4 approved by the plan or the health carrier.

5 9. Nothing in this section shall be construed to require a
6 health care provider to be physically present with a patient
7 where the patient is located unless the health care provider who
8 is providing health care services by means of telehealth
9 determines that the presence of a health care provider is
10 necessary.

11 10. The provisions of this section shall not apply to a
12 supplemental insurance policy, including a life care contract,
13 accident-only policy, specified disease policy, hospital policy
14 providing a fixed daily benefit only, Medicare supplement policy,
15 long-term care policy, short-term major medical [policies of six
16 months' or less] policy with a duration of less than one year, or
17 any other supplemental policy as determined by the director of
18 the department of insurance, financial institutions and
19 professional registration.