Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 4—Submission of Academic Information, Data and New Programs

PROPOSED AMENDMENT

6 CSR 10-4.010 Academic Program Approval. The department is deleting sections (1) and (6), amending sections (2)–(5) and (7)–(10), and renumbering as necessary.

PURPOSE: This amendment sets forth the revised evaluation criteria and procedures for submitting new degree and certificate programs and program changes by public and independent institutions of higher education in Missouri to the Coordinating Board for Higher Education.

[(1) Policy.

(A) In light of its responsibilities imposed and assigned by sections 173.005.2(1) and (7) and 173.030(1) and (2), RSMo, the Coordinating Board for Higher Education (CBHE) has determined that it can and should discharge its obligations by requiring institutions of higher education in the state to submit to it information concerning all new degree and certificate programs. The coordinating board will review all new program proposals and, in the case of public institutions, will approve or disapprove them. In the case of independent institutions, the coordinating board will review the programs and make pertinent recommendations. Although these recommendations are not binding on independent institutions, submission of the proposals is required of independent institutions in order to address the issues of duplication and access at the postsecondary level as well as to enable the coordinating board to fulfill its statutory obligations. Furthermore, compliance with this policy is one (1) of the conditions for the eligibility of independent institutions for participation in the Missouri student grant program.

(B) Sections of this rule that do not apply to independent institutions are those dealing with cooperative intercampus degree programs, staff advisory comments, use of consultants, performance reviews for new programs, joint review with CBHE and the Department of Elementary and Secondary Education and program finances.]

*[(2)]***(1)** Definitions.

(A) *[Certificate—a prescribed course of study which confers an award other than a formal degree.]* **CBHE-approved mission—a description of the public institution's programs, audiences served, level and type of degrees offered, or other distinguishing factors which the CBHE has reviewed and approved.**

(B) *[CIP Taxonomy—the six-digit code number assigned to academic program types by the Center for Educational Statistics of the United States Department of Education. CIP categories are described in the United States Department of Education publication, A Classification of Instructional Programs (CIP).]* **CBHE-approved off-site location—locations other than the main campus (for universities) or taxing district (for community colleges) that the CBHE has reviewed and approved. The department maintains an official inventory of approved off-site locations.**

(C) CBHE-approved service region—a geographic region for which a public institution has responsibility for meeting the educational needs of its residents.

(D) Certificate program—a prescribed course of study which confers an award other than a formal academic degree.

(E) Classification of Instructional Programs (CIP)—a taxonomic scheme that supports the accurate tracking and reporting of fields of study and program completions activity. The CIP is the accepted federal government statistical standard on instructional program classifications developed by the U.S. Department of Education.

(F) Combination programs—the result of a mechanical combination of two (2) previously existing programs.

*[(C)]***(G)** Commissioner—the commissioner of higher education as appointed by the CBHE.

*[(D)]***(H)** Content—the program specialization with its related options, if any, for which recognition is intended to be given by the conferring of a degree or certificate.

*[(E)]***(I)** Coordinating board, board**,** or CBHE—the Coordinating Board for Higher Education created by *[the Omnibus State Reorganization Act, Law 1974, p. 530]* **article IV, section 52 of the Missouri Constitution**.

*[(F)]***(J)** Degree—*[any prescribed course of study in an institution of higher education which constitutes an area of*

specialization leading to a recognized degree. This is the same as the term discipline specialty as represented by the Classification of Instructional Program (CIP) code used in reporting] **an award conferred by a college, university, or other postsecondary education institution as official recognition for the successful completion of a program of studies as defined by and reported** to the United States Department of Education*['s Integrated Postsecondary Education Data System]* and to the *[Missouri]* coordinating board**'s** *[for higher education's]* certificate and program inventory. In baccalaureate degrees or higher, the term program is generally the same as major.

(K) Department—the Missouri Department of Higher Education created by article IV, section 52 of the Missouri Constitution.

(L) Duplication—proposing to offer the same or a similar program to one that is already being offered by another institution.

(M) Inactive status—the result of formal action by an institution on the status of an existing academic program, which suspends the program for a period not to exceed five (5) years.

*[(G)]***(N)** Independent institution—an approved private institution of higher education meeting the requirements of section 173.*[205]***1102**(2), RSMo, provided it is also either accredited or a candidate for accreditation by the *[Commission on Institutions of Higher Education of the North Central Association of Colleges and Secondary Schools and provided it offers a postsecondary course of instruction at least two (2) years in length leading to conferral of a degree]* **Higher Learning Commission**.

*[(H)]***(O)** Level—a degree, such as associate, baccalaureate, first professional, master's, specialist, doctorate**,** and any other designation lower, higher**,** or intermediate to those which now exist or may be created. (Specialist programs, related to the state requirements for the certification of public school administrators and to the further education of public school teachers and supervisors, should be limited specifically to the field of education. These programs are essentially extensions of master's level studies and should evidence a study beyond that expected of master's programs.)

(P) Minor change—modifications to existing programs that do not involve changes to course content, prerequisites, or credit hours, including change of program title or CIP code; combination programs; inactive status; one- (1-) year certificate programs; options; program deletion; single-semester certificate programs.

(Q) Professional Degree—is an award for completing a program that 1) serves as a prerequisite to practicing in the profession; 2) requires at least two (2) years of college work prior to entering the program; and 3) requires a total of at least six (6) academic years of college work to complete the degree program, including prior required college work plus the length of the professional program itself.

*[(I)]***(R)** Program—a prescribed course of study that leads to the formal award of a certificate or degree.

1. Certificate 0 (Undergraduate)—Postsecondary award, certificate, or diploma (less than one (1) academic year) below the baccalaureate degree—

A. Less than nine hundred (900) contact or clock hours; or

B. Less than thirty (30) semester or trimester credit hours; or

C. Less than forty-five (45) quarter credit hours.

2. Certificate 1 (Undergraduate)—Postsecondary award, certificate, or diploma (at least one (1), but less than two (2) academic years) below the baccalaureate degree—

A. At least nine hundred (900), but less than one thousand eight hundred (1,800) contact or clock hours; or

B. At least thirty (30), but less than sixty (60) semester or trimester hours; or

C. At least forty-five (45), but less than ninety (90) quarter hours.

3. Associate's degree—an award that normally requires no more than sixty (60) semester credit hours unless necessary for accreditation or licensure.

4. Certificate 2 (Undergraduate)—postsecondary award, certificate, or diploma (at least two (2), but less than four (4) academic years) below the baccalaureate degree—

A. At least one thousand eight hundred (1,800), but less than three thousand six hundred (3,600) contact or clock hours; or

B. At least sixty (60), but less than one hundred twenty (120) semester or trimester credit hours; or

C. At least ninety (90), but less than one hundred eighty (180) quarter credit hours.

5. Baccalaureate degree—an award that normally requires no more than one hundred twenty (120) semester credit hours unless necessary for accreditation or licensure.

6. Graduate certificate—an organized program of study beyond the bachelor's degree, designed for persons who have completed a baccalaureate degree but not meeting requirements of academic degrees at the master's level.

7. Master's degree—an award that typically requires successful completion of a program of study of at least the full-time equivalent of one (1), but not more than two (2) academic years of work beyond the bachelor's degree. Some of these degrees may require more than two (2) full-time equivalent academic years of work.

8. Post-master's certificate (First-professional certificate)—an organized program beyond the master's degree but not meeting requirements of academic degrees at the doctor's level. This award is designed for persons having completed the first-professional degree (refresher courses or additional units of study in a specialty or subspecialty).

9. Doctoral degree—the highest award a student can earn for graduate study (research/scholarship or professional practice).

(S) Program deletion—the removal of a program or an option from an institution's program offerings.

(T) Program change—any revision or change in a program name or its nomenclature, including CIP number.

*[(J)]***(U)** Public institution—an approved public institution of higher education meeting the requirements of section 173.*[205]***1102**(3), RSMo*[, provided it is also either accredited or a candidate for accreditation by the Commission on Institutions of Higher Education of the North Central Association of Colleges and Secondary Schools, and provided it offers a postsecondary course of instruction at least two (2) years in length leading to conferral of a degree]*.

*[(K)]***(V)** Program option*[s]* **or option**—a formally designated area of specialization within an existing degree program that has a distinctive curricular pattern. A *[preponderance]* **majority** of required courses for the option will be taken in a core of courses common to all variations of the existing parent degree. For the purposes of program changes, option, emphasis area**,** and other similar terms are assumed to be equivalent.

(W) Substantive curricular change—significant modifications or expansion of an existing program. Examples of substantive changes include, but are not limited to, a change in the program's overall credits or goals; deletion and replacement of a significant number of courses in the program's curriculum; change in the primary mode of delivery; change in the program's purpose; change in the audience(s) that the program is intended to serve.

*[(L)]***(X) Program** *[T]*type **or type of program**—A designation within a degree level, such as associate of arts(AA), associate of science (AS), associate of applied science (AAS), bachelor of arts, bachelor of science, bachelor of science in engineering, master of arts, master of science, doctor of philosophy, doctor of education, etc. *[AA and AS degrees are oriented toward transfer to baccalaureate*

programs. AAS degrees are not oriented toward transfer to baccalaureate programs, but rather are terminal vocational programs.]

*[(3)]***(2)** *[General Program Approval]* **Special** Procedure*[s]* for **New** Public Institutions.

[(A) The coordinating board or its designee shall be responsible for the review of all new program proposals and shall either approve or disapprove them. Institutions submitting new programs for CBHE review shall follow the format outlined by CBHE staff. Submissions shall be made on appropriate forms as provided by the CBHE. All actions resulting in the approval of new programs for public institutions shall be subject to a stipulation regarding the program's ability to attain specified performance goals during a stipulated period that shall have been established by the sponsoring institution and shall have been approved by the board or its designee.

(B) Performance Review. At the conclusion of the stipulated period, the program's performance shall be reviewed on the basis of the specified goals in a manner mutually satisfactory to the sponsoring institution and the commissioner. In the event a new program fails to develop satisfactorily in the allotted period as determined by the board or its designee, the status of the new program shall be evaluated. As a result of this review, approval may be continued with or without further stipulations, or program authorization may be withdrawn. In the latter event, should the sponsoring institution choose to continue the new program rather than terminate it, the resources associated with the program shall be withdrawn from the institution's funding base for the purpose of developing future state appropriation requests.

(C) Special Procedure for New Public Institutions.]

*[1.]***(A)** Since newly-established public institutions have ordinarily only begun the process of assembling the resources necessary to offer instruction, application of the usual *[and customary]* review process would *[not]* be **in**appropriate. As a consequence, new public institutions must develop a five- (5-)*[-]* year academic plan that projects those programs the institution intends to develop during this period based upon a need analysis it has conducted. The institution must also provide satisfactory evidence that it can reasonably expect to acquire the resources necessary to support these programs. The institution must submit annual updates on the plan and its progress toward full implementation. At these times the institution may request revisions in its original plan.

*[2.]***(B)** Subject to *[coordinating board]* **CBHE** approval of the plan, the new institution may offer these programs for a period not to exceed five (5) years. During this time the institution must submit formal proposals for new program approval; however, the submission of these programs may occur on a schedule convenient to the institution. Those programs that have not received regular approval by the end of the five- (5-)*[-]* year planning period shall be terminated, or the resources associated with the program shall be withdrawn from the institution's funding base for the purpose of developing future state appropriation requests.

*[(D)]***(C)** Notice. Prompt notice of the results of all academic program approval and review actions by the board or its designee, including any pertinent comments relating thereto, *[shall]* **will** be sent to the *[Coordinating Board for Higher Education]* **CBHE** whenever the action decision has been delegated, to all higher education institutions and to the public in a manner deemed appropriate by the commissioner.

*[(4)]***(3)** General Program Review *[Policies]* for Independent Institutions. **Except for subsections (4)(A), (4)(B), the right to appeal provided in section (8), and any pertinent definitions in section (1), this rule does not apply to independent institutions. Independent institutions shall submit all new degree and certificate programs for CBHE review according to the procedure in either subsection (4)(A) or (4)(B), as determined by department staff. The CBHE may offer nonbinding recommendations on such program proposals, and may use submitted information to aid the analysis of public institutions' program proposals. Submission of new program information is a prerequisite to receiving any funds administered by the CBHE in accordance with section 173.005.2(9) and (10), RSMo, but receipt of such funds does not depend on receipt or compliance with CBHE comments or recommendations. In no event, section (4) of this rule notwithstanding, will independent institutions' program proposals be subject to CBHE approval.**

[(A) Independent institutions shall submit all new degree and certificate programs for coordinating board review. Institutions submitting new programs for CBHE review shall follow the general format used by public institutions. Submissions should be made on appropriate forms as provided by the CBHE.

(B) The board or its designee shall review new program proposals submitted by independent institutions and may make pertinent comments and recommendations. Although these recommendations are not binding on independent institutions, submission of the proposals is required of independent institutions to address the issues of duplication and access at the postsecondary level as well as to enable the CBHE to fulfill its statutory obligations. Compliance with this policy is one (1) of the conditions for the eligibility of independent institutions for participation in the Missouri student grant program.

(C) The board or its designee shall ensure that the review of new programs submitted by independent institutions is conducted in a manner to provide that all criteria and definitions that are applicable to public institutions are also applicable to independent institutions except as explicitly provided in this rule. These criteria, however, shall be applied with due regard for the differences between public and independent institutions as well as the different degree of responsibility and authority the coordinating board and state have in the operation of the respective sectors.

(D) With respect to permissible differences in the review process between independent and public institutions, the following criteria, procedures and definitions shall not be applicable to independent institutions unless an individual independent institution should voluntarily elect to participate in a particular review provision:

1. All financial criteria shall not be applicable and related data should not be submitted;

2. Provisions related to cooperative intercampus degree programs shall not be applicable;

3. Provisions related to staff advisory comments shall not be applicable;

4. Provisions related to performance reviews for new programs shall not be applicable;

5. Provisions related to the use of consultants shall not be applicable; and

6. Provisions related to the joint review of vocational programs by the coordinating board and the Department of Elementary and Secondary Education shall not be applicable.

(E) Notice. Prompt notice of the results of all academic program review actions by the CBHE or its designee, including any pertinent comments relating thereto, shall be sent to the Coordinating Board for Higher Education whenever the action decision has been delegated, to all higher education institutions and to the public in a manner deemed appropriate by the commissioner.]

(4) Types of Review.

(A) Staff Review.

1. Minor changes to existing academic programs and the addition of some certificates may be addressed through a staff review. Institutions shall report all minor changes to ensure that the state program inventory is accurate and complete.

2. Requests for minor changes to existing academic programs must be submitted to the department on forms provided by the department. The following guidelines apply to specific change requests:

A. Moving an existing program to inactive status.

(I) Programs placed on inactive status will be suspended for a specified period not to exceed five (5) years.

(II) Students in the program at the time this status is adopted will be permitted to conclude their course of study if they have no more than two (2) years of coursework remaining, but no new students may be admitted to the program.

(III) At the conclusion of the designated inactive period, not to exceed five (5) years, the institution must review the program's status and may either delete it or reactivate it.

(IV) Only programs and certificates may be placed in inactive status; options are deleted through the program deletion process;

B. Program deletion. At the time an institution notifies the Higher Learning Commission (HLC) in writing about the circumstances for which HLC requires a teach-out agreement, the institution must also notify the department. Institutions must provide program name, level, CIP code, and effective date of deletion;

C. Location notification. This includes change of address updates, and notifications of closed locations. Notifications of closed locations must also include the list of programs to be deleted at the location;

D. Change of program title or CIP code. A title, CIP code, or nomenclature revision that includes substantive curriculum changes may be deemed tantamount to a new program and may be referred to the institution for consideration at the routine or comprehensive review level;

E. Combination programs. Combination programs will be reviewed at the staff review level for the elimination of duplicated requirements. The development of interdisciplinary programs and area study programs that utilize the resources of several existing programs will be reviewed through the routine or comprehensive new program approval process. However, proposals that combine two (2) or more programs ordinarily involve a substantive curricular change, which must be reviewed in the comprehensive process described in subsection (5)(C);

F. Certificate programs. Single-semester certificate programs, either as a stand-alone or as part of a parent-degree program, will be considered under staff review. A one- (1-) year certificate may be considered under staff review only if developed from, directly related to, and deriving courses predominantly from an approved parent degree program. Otherwise, one- (1-) year certificate proposals must be submitted as a new program at the routine or comprehensive review level, as appropriate;

G. Graduate certificates. Graduate certificates greater than a single semester in length may be approved at the staff review level if they are part of an existing approved parent degree program. Graduate certificates greater than a single semester that are not part of an approved parent degree must be submitted as a new program at the routine or comprehensive review level, whichever is appropriate; and

H. Adding an option to an existing program. The addition of a specialized course of study as a component of an umbrella degree program may be submitted as a program change subject to a determination by the CBHE or its designee regarding the potential for unnecessary or inappropriate duplication of existing programs, in accordance with subsection (9)(C) of this rule. Only in those instances in which duplication is necessary and appropriate may the proposed option be implemented. Options within a parent degree program will have the same CIP code as the parent degree. The institution shall provide evidence that the proposed option functions as a component of an umbrella degree program, including the curriculum common to the parent degree and all of its options.

(I) The following general guidelines distinguish a permissible option addition from a proposed new degree program:

(a) An option or emphasis area generally functions as a component of an umbrella degree program. As such, an option in a specialized topic will consist of a core area of study in the major plus selected topical courses in the specialty. Typically, the core area of study will constitute a majority of the requirements in the major area of study as measured in the number of required courses or credit hours;

(b) A proposed option or emphasis area must be a logical component or extension of the umbrella degree program. One (1) measure of this compatibility—but not the only one—would be the consonance of the proposed addition with the federal CIP taxonomy. For instance, using physics as an example, optics would be an appropriate option (emphasis area) while astrophysics would ordinarily not be acceptable as it is typically viewed as a branch of astronomy rather than physics;

(c) The number of new courses required to implement a new option or emphasis area is relevant. Four (4) or more new courses in a proposed new option will raise questions about resource commitments and suggest that a new program has been developed; and

(d) The need to develop new courses as a condition of implementing an option is a relevant consideration.

3. Review and reporting. Department staff will review requests for minor changes to existing academic programs. Department staff may request additional information from the proposing institution.

4. Timeline. For all requests submitted by the first of the month, department staff will process, review, and report back to institutions by the end of that same month. Department staff will report routine review actions to the CBHE at the next regular board meeting following completion of review.

(B) Routine Review.

1. Proposals for new academic programs that are not minor, but do not constitute a significant change in an institution's current role, scope, or mission will be reviewed under the routine review process. For a proposed program to be considered through routine review, it must meet all of the following criteria:

A. The program is clearly within the institution's CBHE-approved mission;

B. The program will be offered within the proposing institution's CBHE-approved service region;

C. The program will not unnecessarily duplicate an existing program in the applicable geographic area, as described in subsection (9)(C) of this rule;

D. The program will be offered at the main campus or at a CBHE-approved off-site location;

E. The program will build on existing programs and faculty expertise; and

F. The cost to launch the program will be minimal and within the institution's current operating budget.

2. The following proposals generally will be considered under the routine review process:

A. Substantive curricular changes to an existing program;

B. Delivery of an approved program at a CBHE-approved off-site location; and

C. New degree programs offered in collaboration with an institution already approved to offer such a program.

3. Process.

A. Institutions shall provide information about the proposed program to the department on forms provided by the department. This information will include certification that the

proposal meets the criteria for routine review and that the program meets the criteria for all new academic programs. Department staff may request additional information from the proposing institution.

B. Department staff will verify and post the proposal on the department's website to allow for twenty (20) days of public review and comment. Any institution, member of the profession, occupation, or specialized academic field, and any other interested individual may express an opinion to department staff regarding any new program proposal. Comments must be received within twenty (20) days of the proposal's posting on the department website.

C. The proposing public institution will address comments and feedback received. Once all concerns are resolved, the commissioner will recommend provisional approval of the program for a period of five (5) years.

(I) The public institution shall establish clearly defined performance goals for the new program to be achieved during the provisional implementation period. The public institution may revise its performance goals for the new program at any time during the designated implementation period with the concurrence of department staff.

(II) Provisional approval by the CBHE or its designee is valid for two (2) years following the first fall term after CBHE approval. If an institution has not implemented the proposal by that date, the approval will lapse and the program proposal must be resubmitted with updated information.

D. At the end of the five- (5-) year provisional approval period, the department will review the program's viability to determine whether the CBHE's provisional approval should become unconditional, remain provisional pending further review in two (2) years, or be terminated.

(I) Public institutions shall provide to department staff, in a manner prescribed by department staff, enrollment, graduation, and staffing data for the program, as well as a brief summary of program performance. If the program is performing as well as or better than the projections in the original program proposal, the department will recommend that the CBHE approve the program unconditionally.

(II) If the CBHE terminates provisional approval, the public institution shall take the necessary steps to close the program, which includes accommodating students currently enrolled in the program.

4. Timeline.

A. Requests submitted by the first of the month will be reviewed and processed, and in most cases institutions will be notified, by the end of that same month. Department staff will report routine review actions to the CBHE at the next regular board meeting following completion of review.

(C) Comprehensive Review.

1. Proposed new academic programs that meet any of the following criteria will be subject to a comprehensive review:

A. The program will be offered outside the institution's CBHE-approved service region;

B. The institution will incur substantial costs to launch and sustain the program;

C. The program will include the offering of degrees at the baccalaureate level or higher that fall within the Classification of Instructional Programs (CIP) code of 14, Engineering;

D. The program is outside an institution's CBHE-approved mission;

E. The program will include the offering of a doctoral degree, as further described in paragraph (9)(C)3. of this rule (applicable only to non-University of Missouri institutions);

F. The program will include the offering of a professional degree, as further described in paragraph (9)(C)3. of this rule (applicable only to non-University of Missouri institutions); or

G. The program will include the offering of an education specialist degree.

2. Elements of a Complete Proposal for Comprehensive Review. Institutions shall submit the proposal to the department on forms provided by the department. A complete proposal includes the following:

A. Evidence of good faith effort to explore the feasibility of collaboration with other institutions whose mission or service region encompasses the proposed program. At a minimum, this will include letters from the chief academic officers of both the proposing institution and other institutions involved in exploring the feasibility of collaborative attesting to the nature of the discussions and explaining why collaboration in this instance is not feasible;

B. Evidence that the offering institution is contributing substantially to the CBHE's *Blueprint for Higher Education* as adopted on February 4, 2016, pursuant to section 173.020(4), RSMo, and is committed to advancing the goals of that plan;

C. Evidence of institutional capacity to launch the program in a high-quality manner, including:

(I) An external review conducted by a team including faculty experts in the discipline to be offered and administrators from institutions already offering programs in the discipline and at the degree level proposed. The review must include an assessment of the offering institution's capacity to offer the new program in terms of general, academic, and student service support, including faculty resources that are appropriate for the program being proposed (e.g. faculty credentials, use of adjunct faculty, and faculty teaching workloads);

(II) A comprehensive cost/revenue analysis summarizing the actual costs for the program and information about how the institution intends to fund and sustain the program;

(III) Evidence indicating there is sufficient student interest and capacity to support the program, and, where applicable, sufficient capacity for students to participate in clinical or other external learning requirements, including library resources, physical facilities, and instruction equipment; and

(IV) Where applicable, a description of accreditation requirements for the new program and the institution's plans for seeking accreditation; and

D. Evidence that the proposed program is needed, including:

(I) Documentation demonstrating that the program does not unnecessarily duplicate other programs in the applicable geographic area, as described in subsection (9)(C) of this rule;

(II) A rigorous analysis demonstrating a strong and compelling workforce need for the program, which might include data from a credible source, an analysis of changing program requirements, the current and future workforce, and other needs of the state, and letters of support from local or regional businesses indicating a genuine need for the program; and

(III) A clear plan to meet the articulated workforce need, including:

(a) Aligning curriculum with specific knowledge and competencies needed to work in the field(s) or occupation(s) described in the workforce need analysis in part (II) of this subparagraph;

(b) Providing students with external learning experiences to increase the probability that they will remain in the applicable geographic area after graduation; and

(c) A plan for assessing the extent to which the new program meets that need when implemented.

3. Process.

A. Department staff will verify and post the proposal on the department's website to allow for twenty (20) days of public review and comment. Any institution, member of the profession, occupation, or specialized academic field, and any other interested individual may express an opinion to department staff regarding

any new program proposal. Comments must be received within twenty (20) days of the proposal's posting on the department's website.

B. Department staff, in consultation with the external review team described in part (4)(C)2.C.(I) of this rule, will review a complete proposal and provide feedback to the proposing institution.

C. The proposing public institution will address comments and feedback received. Once all concerns are resolved, the commissioner will recommend provisional approval of the program for a period of five (5) years.

(I) Public institutions shall establish clearly defined performance goals for the new program to be achieved during the provisional implementation period. The public institution may revise its performance goals for the new program at any time during the designated implementation period with the concurrence of department staff.

(II) Public institutions must report annually to the CBHE on the number of students completing the program, financial performance of the program, job placement rates of program graduates, success on any applicable licensure exams, and the extent to which the program is meeting the needs it was designed to address.

(III) Provisional approval by the CBHE or its designee is valid for two (2) years following the first fall term after CBHE approval. If an institution has not implemented the proposal by that date, the approval will lapse and the program proposal must be resubmitted with updated information.

D. At the end of the five- (5-) year provisional approval period, the department will review the program's viability to determine whether the CBHE's provisional approval should become unconditional, remain provisional pending further review in two (2) years, or be terminated.

(I) Public institutions shall provide to department staff, in a manner prescribed by department staff, enrollment, graduation, and staffing data for the program, as well as a brief summary of program performance. If the program is performing as well as or better than the projections in the original program proposal, the department will recommend that the CBHE approve the program unconditionally.

(II) If the CBHE terminates provisional approval, the public institution shall take the necessary steps to close the program, which includes accommodating students currently enrolled in the program.

4. Timeline.

A. Proposals must be submitted to the CBHE by July 1 of each year. The CBHE, in its sole discretion, will determine which proposals to evaluate, and will announce its evaluation decision(s) in September. Final decisions to approve programs will ordinarily be made by February.

B. Comprehensive reviews will be phased in to the program approval process.

(I) In the 2017-2018 review cycle, the CBHE will consider no more than three (3) proposals, in total, to offer a degree outside an institution's CBHE-approved mission. No more than two (2) proposals may come from either public universities or public two- (2-) year institutions during this review cycle.

(II) In the 2018-2019 review cycle, the CBHE will consider no more than five (5) proposals, in total, to offer a degree outside an institution's CBHE-approved mission. No more than three (3) proposals may come from either public universities or public two- (2-) year institutions during this review cycle.

(III) If changes to statutes or licensure requirements warrant the authorization of more than one (1) institution to propose a program requiring a comprehensive review, such proposals may be considered as a single proposal for purposes of this section only.

(IV) Each individual institution's proposal will be evaluated on its own merits.

(V) After two (2) proposal cycles, the CBHE may reconvene a task force to evaluate the new framework and to recommend improvements for the CBHE's consideration.

(5) *[Submission of Proposals]* **Off-campus and Out-of-district Degrees and Courses**.

[(A) Program Review Schedule.

1. Except as otherwise noted in this rule, proposals for degree and certificate programs must be submitted at least one hundred twenty (120) days prior to implementation and should be submitted to the Missouri Coordinating Board for Higher Education during one (1) of the following three (3) periods each year:

A. March 1 through March 31;

B. July 1 through July 31; and

C. November 1 through November 30.

2. Every effort will be made to complete the review of proposals received in each of these periods during the following one hundred twenty (120)-day cycles (which will begin on April 1, August 1 and December 1), unless unusual circumstances require more time for review of a particular program. The CBHE or its designee may permit departure from this schedule, if necessary, but the sponsoring institution shall be notified of the delay and the reasons for it. The sponsoring institution may request an expedited review of a proposed program in extenuating circumstances by informing the commissioner in writing of the reasons for the request. Pending degree programs shall not be implemented until coordinating board action has been completed.

(B) Off-campus and Out-of-district Degrees and Courses.]

*[1.]***(A)** In addition to submitting **proposals for** new certificate and degree programs for on-campus offerings, an institution must submit a new program proposal if more than half the major requirements for the degree can be completed at an off-campus site for four- (4-)*[-]* year institutions or at an out-of-district site for two- (2-)*[-]* year institutions. (For the purposes of this section, major requirements *[shall be considered to]* include course requirements in the specific area of concentration only; general education requirements and free electives *[shall]* **will** not be a factor in this determination.)

*[2.]***(B)** All formal two-plus-two (2 + 2) curricular agreements must be submitted for review if either the sponsoring institution or the host institution is publicly supported.

(C) *[Instructional Site Defined. In the context of the previous subsection, instructional site shall be defined to include only those settings where instruction is delivered directly to students by a physically present teacher. Internship sites and the simple receipt of telecommunications transmissions shall ordinarily not constitute an instructional site. However, programs identified for delivery by such nontraditional means as telecommunications must be submitted for review, and the subsequent review shall focus on instructional delivery at the point of origin. All customary review criteria shall be applicable to programs delivered by nontraditional means.]* **Types of Off-Campus Instructional Sites Requiring CBHE Approval. The following off-campus instruction sites require CBHE approval:**

1. Residence centers, as defined in 6 CSR 10-6.020(1);

2. Off-campus instruction as defined in 6 CSR 10-6.030(1)(C); and

3. Out-of-district instruction as defined in 6 CSR 10-6.030(1)(D).

(D) Special Procedure for Multiple-campus Institutions.

1. Multiple-campus four- (4-)*[-]* year institutions must submit separate program proposals for individual campuses, subject to certain exceptions for cooperative degree programs that are defined in subsequent paragraphs. For the purposes of cooperative degree programs, residence centers *[shall]* **are** not *[be regarded as]* separate

campuses.

2. New program authorization for one (1) campus of a multiple-campus two- (2-)*[-]* year public institution may be extended to all other campuses within a district at the discretion of the sponsoring institution *[subject to the stipulation that]***, provided** the *[coordinating board shall be informed]* **sponsoring institution informs the CBHE** of all academic programming available at each campus.

(E) Cooperative Intercampus Degree Program for Public Institutions.

1. A cooperative*[,]* intercampus degree program extends an academic program authorized by the CBHE on one (1) of an institution's campuses to one (1) or more of its other campuses (not including residence centers) under the following conditions:

A. The campus authorized to provide the program will continue to do so;

B. The program is cooperative in nature, that is, it involves the faculty and resources of each participating campus;

C. The program *[shall]* **must** be included in the institution's plan and *[shall]* be consistent with the mission statement for the receiving campus; and

D. The program *[shall]* **must** meet the accreditation guidelines of the appropriate national accrediting body, if any exists, as well as any applicable state licensure requirements.

2. Subject to the previously mentioned definition, a cooperative*[,]* intercampus program is distinct from the more typical new program model in which a program is developed as a new, free-standing entity on a campus.

3. The procedures and criteria for the review of *[these]* **cooperative intercampus** programs *[shall be]* **are** the following:

A. Following the endorsement by the president and the governing board of the institution, the program shall be sent to the *[board]* **CBHE** or its designee for review **at least one hundred twenty (120) days prior to the proposed implementation**;

[B. Each cooperative, intercampus program shall be shared with the CBHE staff for its review and consideration at least one hundred twenty (120) days prior to the proposed implementation;]

*[C.]***B.** It *[shall be]* **is** the institution's responsibility to document the economic development opportunity or the need the proposed program is designed to address, including specific *[manpower]* **workforce** needs at the state or regional level;

*[D.]***C.** Additional expenditures associated with the proposed program *[shall]* **will** be defined. If the resource needs cannot be satisfactorily addressed by internal reallocation or alternative delivery systems, the program *[shall]* **will** be included in the institution's next budget request for state support; and

*[E.]***D.** The *[board]* **CBHE** or its designee *[shall]* **will** review the cooperative*[,]* intercampus program on an expedited basis involving a period not to exceed sixty (60) days. In the event the program is not approved by the board's designee, the decision may be appealed to the *[coordinating board]* **CBHE** following established program appeal procedures.

[4. This subsection is not applicable to independent institutions.

(F) Staff Advisory Comment for Public Institutions.

1. The first step in the approval process for free-standing new degree programs is known as the staff advisory comment (SAC) and applies to public institutions only. The SAC report enables the coordinating board staff to make preliminary judgments regarding a program proposed by a public institution prior to the preparation of an entire program proposal document and initiation of the internal approval process at the institutional level. The process also enables the sponsoring institution to anticipate and address issues that might be relevant during the full review. A favorable staff advisory comment does not guarantee final approval of the program when staff reviews the full proposal. Conversely, an unfavorable staff advisory comment does not necessarily mean that the final proposal for a program will not be approved. It will be expected, however, that staff concerns expressed in the staff advisory comment will be addressed in the final proposal.

2. The SAC report will emphasize those program approval criteria listed in this rule which are relatively stable in the short- to mid-term and which cannot be readily adjusted to different circumstances or perceived needs.

A. Mission and planning priorities of sponsoring institution. Each proposal shall include a statement regarding the compatibility of the proposed program with an institution's mission and approved institutional plan or plan update.

B. Need for the proposed program. Each proposal shall address the issues of what are the societal, occupational, research and public service needs the program is intended to address as well as the anticipated student demand for the program, preliminary evidence related to market demand for program graduates and the relationship of the program to the economic development of the state, as may be appropriate.

C. Duplication of the proposed program. Each proposal shall comment on the issue of the extent to which any existing programs in the proposed service area already address the needs and purposes this program is designed to fulfill. Factors salient to the duplication issue include the relevance of existing programming, the availability of alternative educational delivery systems, extent of student demand, state or regional manpower requirements and access considerations.

3. To provide a frame of reference so the responses to these questions can be properly understood, it will also be necessary to submit a brief description of each program including an outline of the proposed curriculum. The structure of the proposed curriculum will not be subject to comment in this phase of the review process, and the CBHE staff will assume that the details of these descriptive materials may be subject to modification as the program development process proceeds. However, if additional planning suggests that a major shift in program emphasis would be appropriate, a new document must be submitted for a staff advisory comment.

4. All documents related to this process should be submitted in duplicate. Materials related to a staff advisory comment may be submitted at any time during the year. Every effort will be made to complete a staff advisory comment within forty-five (45) days of submission.

(G) Proposal for a New Academic Degree Program.

1. A proposal for a new academic degree program shall be submitted during one (1) of three (3) specified submission periods: March, July or November. All documents related to this process should be presented in triplicate in the form prescribed by CBHE staff. The board staff may request information in addition to that contained in the proposal.

2. Approval by the CBHE or its designee of new degree and certificate program proposals submitted by public institutions as well as the formal receipt of new programs from independent institutions are valid for two (2) years following the first fall term after the action. If an institution has not implemented the program by that date, the approval or receiving shall be considered to have lapsed and the program proposal must be resubmitted with updated information.

3. Any institution or interested party, that is, a representative from another institution, of the profession, occupation, or specialized academic field, or any individual who, as a potential student or employer, believes him/herself to be affected by the proposed program, may express an opinion to the coordinating board or its designee regarding the evaluation

or recommendation of any new degree program proposal. This may also occur when an institution or individual wishes to comment on a degree program submitted by another institution. In addition, a formal appeal of a program action may be initiated as provided elsewhere in this rule.

4. Proposal for a new AS transfer degree program.

A. The AS degree is a specialized degree which is intended for transfer into a preprofessional program and is substantively different from the AAS degree. The AAS degree is not intended as a transfer degree into a four (4)-year program and contains courses that are not primarily designed for transfer. Students seeking to transfer this degree will have their transcripts evaluated on a course by course basis.

B. The AS degree should result from careful planning and should constitute an articulation agreement between specific institutions.

C. The primary intent of the AS degree is to provide an alternative to the AA degree in those limited instances when the model general education program included in the AA degree cannot accommodate the demands of a preprofessional program. The AS degree shall be used only in exceptional circumstances when no other remedy is available.

D. The AS degree is to be developed through consultation between sending and receiving institutions on a program-by-program basis. Proposed AS degree programs may be submitted at any time of the year and will be reviewed using a modified program review process. The emphasis of this review will be on the justification for establishing an exception to the prescribed thirty-nine (39)- hour general education core requirement and the resource implications of the proposed agreement for the sending institution. Submission of a staff advisory comment request is not required for proposed programs of this type.

(6) Program Changes. Changes in programs must be submitted to the coordinating board for both informational and review purposes. After considering these changes, the board or its designee may determine that the change in program should be submitted instead as a new program proposal. Program changes should be reported using appropriate forms provided by the CBHE. Program changes that should be submitted include the following:

(A) Program Title Change All revisions or changes in a program name or its nomenclature shall be reported to the CBHA title or nomenclature revision that includes substantive curriculum changes may be deemed tantamount to a new program and be referred back to the institution for resubmission as a new program;

(B) Combination Programs.

1. This category is narrowly defined to include only those programs that result from a mechanical combination of two (2) previously existing programs. Substantive curricular changes shall ordinarily be limited to the elimination of duplicated requirements.

2. The development of interdisciplinary programs and area study programs that utilize the resources of several existing programs shall be handled through the new program approval process.

(C) Single Semester Certificates. A single semester certificate may be added or deleted simply by using a Notice of Changes in Programs form provided by the CBHE. The establishment of a longer program, however, shall be pursued through the procedures established in this rule;

(D) One (1)-year Certificate Programs.

1. A one (1)-year certificate program developed from an approved associate degree program shall be reported as a program change provided that the program is directly related to the approved associate degree program and consists predominantly of courses included in the associate degree program.

2. A one (1)-year certificate not associated with an approved parent degree program must be submitted as a new program;

(E) Option Addition.

1. The addition of a specialized course of study as a component of an umbrella degree program may be submitted as an option addition program change subject to the limitation that the CBHE or its designee shall make a determination regarding the potential for unnecessary or inappropriate duplication of existing programs. Only in those instances in which duplication is not a problem may the proposed option be implemented.

2. The following general guidelines are used to distinguish a permissible option addition from a proposed new degree program:

A. At the conceptual level an option or emphasis area functions as a component of an umbrella degree program. As such, an option in a specialized topic shall consist of a core area of study in the major plus selected topical courses in the specialty. Typically, the core area of study shall constitute a preponderance of the requirements in the major area of study as measured in the number of required courses or credit hours, but no specific percentage distribution requirement has been established;

B. A proposed option or emphasis area shall be a logical component or extension of the umbrella degree program. One (1) measure of this compatibility—but certainly not the only one—would be the consonance of the proposed addition with the federal CIP taxonomy. For instance, using physics as an example, optics would be an appropriate option (emphasis area) while astrophysics would ordinarily not be acceptable as it is typically viewed as a branch of astronomy rather than physics; and

C. The number of new courses required to implement a new option or emphasis area can also be a relevant consideration. Four (4), five (5) or more new courses in a proposed new option would tend to raise questions about resource commitments and suggest that a new program has been developed;

(F) Inactive Status for Existing Programs.

1. Programs placed on inactive status will essentially be suspended for a specified period not to exceed five (5) years. Students in the program at the time this status is adopted shall be permitted to conclude their course of study if they have no more than two (2) years of course work remaining, but no new students may be admitted to the program. Programs designated as inactive will be so noted on institutional program inventories.

2. At the conclusion of the designated inactive period—not to exceed five (5) years—the institution must review the program's status and may either delete it or reactivate it.

3. In the event the institution chooses to reactivate the program, the institution shall provide the coordinating board satisfactory evidence that the resources necessary for the program are available and must establish performance goals for the program that are also acceptable to the coordinating board; and

(G) Deletion and Consolidation of Programs. Institutions must submit standard program change information whenever a program or option is deleted. This same provision applies whenever two (2) or more programs or options are to be consolidated into one (1) or more new offerings.]

*[(7)]***(6)** Use of Consultants.

(A) In addition to evaluating written proposals, the board or its designee, in some circumstances, may use the services of consultants. It is anticipated that this procedure will be used *[infrequently]* **primarily for comprehensive reviews**.

(B) These consultants *[shall]* **must** be individuals who are mutually acceptable to the board and to the **public** institution whose program is under consideration. Both the commissioner and the **public** institution may recommend consultants, but the ultimate selection of the consultant *[shall]* **must** be agreeable to both.

(C) Services of consultants will be paid for by the **public** institution whose program is pending.

(D) Consultants may be used in the following circumstances:

1. At the request of either the commissioner or the **public** institution pending an unfavorable recommendation by *[the coordinating board]* **department** staff;

2. For some health-related professions or high technology programs whenever clinical facilities, laboratory facilities, equipment**,** or other aspects of the program need professional evaluation; or

3. In instances in which a judgment is difficult to make without the evaluation of professionally qualified external consultants.

*[(8)]***(7)** Programs Reviewed Jointly by the Coordinating Board for Higher Education and the Department of Elementary and Secondary Education.

(A) A*[n]* **public** institution requesting financial reimbursement for a new program from vocational/technical funds administered by the Department of Elementary and Secondary Education must submit at the same time *[two (2) copies]* **a copy** of the proposal in the CBHE's format to the Division of Career and Adult Education of the Department of Elementary and Secondary Education in accordance with the instructions of that office. *[Because independent institutions are not eligible for reimbursement under this program, this section does not apply to independent institutions.]*

(B) The coordinating board and the Department of Elementary and Secondary Education concur on the following procedures and understandings for effecting cooperation between the two (2) agencies in the exercise of their respective responsibilities regarding the development of vocational/technical programs in Missouri colleges and universities:

1. The responsibilities of the Department of Elementary and Secondary Education to approve courses of instruction for vocational/technical financial reimbursement and of the *[coordinating board]* **CBHE** to approve new degree and certificate programs are independent responsibilities and are not contingent one upon the other. However, as a general policy the Department of Elementary and Secondary Education will not approve financial reimbursement requests which are components of degree or certificate programs not approved by the coordinating board;

[2. In order to avoid duplication of effort by institutions, the Department of Elementary and Secondary Education will employ the coordinating board's proposal format for submission of new program proposals as its instrument for fiscal reimbursement requests;]

*[3.]***2.** *[Coordinating Board for Higher Education]* **CBHE** staff will notify Department of Elementary and Secondary Education staff of the development of any vocational/technical program, and members of both staffs will confer on all vocational/technical degree and certificate programs submitted to the coordinating board; and

*[4.]***3.** The Division of Career and Adult Education of the Department of Elementary and Secondary Education will receive notification of the commissioner's actions on all vocational/technical program proposals.

*[(9)]***(8)** Appeal Procedure. In the event of an appeal of a program review action for *[either]* a public *[or independent]* institution, the following procedures *[shall be followed]* **apply**:

(A) Any of the following parties may initiate an appeal of a program action decision:

1. The **public** institution submitting the original proposal;

2. Any Missouri higher education institution that believes its interests are adversely affected by the program decision; or

3. Any member of the *[Coordinating Board for Higher Education]* **CBHE**, in the event the original decision was made by the board's designee;

(B) An appeal originating with a higher education institution must be signed by the chief executive officer of the institution;

(C) A letter of intent to appeal must be received by the commissioner *[of higher education]* within thirty (30) days of receipt of the official notice of the program decision. If the appeal is initiated by a party other than the **public** institution that proposed the program, a copy of the intent to appeal letter and all other subsequent documentation must be sent to the sponsoring institution;

(D) The new program may not be implemented while an appeal is pending;

(E) Within fourteen (14) days after a letter of intent to appeal has been submitted, the appealing party must submit its full rationale in support of the appeal to the commissioner and to any affected institutions. This rationale should summarize the appellant's justification for a review of the program decision and should include any relevant supporting evidence;

(F) This rationale and the responses of the commissioner and any affected institutions will be placed on the agenda of the next meeting of the *[Coordinating Board for Higher Education]* **CBHE**, provided that the next meeting is scheduled at least fourteen (14) days after receipt of the rationale. If *[this criterion is not satisfied]* **the rationale is received less than fourteen (14) days before the next meeting**, the request for an appeal will be heard by the *[board]* **CBHE** at its next regularly scheduled meeting;

(G) *[If a majority of the Coordinating Board for Higher Education agrees that an appeal initiated by an institution should be heard, the matter will be referred to the CBHE committee on academic and library affairs]* **The CBHE chair will refer the matter to a relevant committee of the CBHE**. A public meeting of the committee will be scheduled at which time testimony will be presented by all interested parties, and the committee *[shall]* **will** make its determination;

(H) In those instances when a member of the *[coordinating board]* **CBHE** has initiated a review of a decision by the board's designee, the chair*[man]* of the board *[shall]* **will** receive copies of all relevant documents. Provided that a majority of the board agrees that an appeal should be heard, the board may decide either to refer the matter to *[the]* **a relevant** committee *[on academic and library affairs or to hear the appeal itself]* **of the CBHE**. If the matter is heard by the committee, the same procedures *[shall]* **will** apply as if the appeal were initiated by an institution. If the matter is heard directly by the board, the chair*[man]* of the board *[shall]* **will** establish the appropriate procedural guidelines; **and**

(I) All decisions of the body hearing the appeal, whether the full *[coordinating board]* **CBHE** or its committee *[on academic and library affairs, shall]***, will** be final*[; and]***.**

[(J) This section on appeal procedures is intended to be applicable to both public and independent institutions, but no provision of this section shall supersede the general principle that decisions or recommendations by the Coordinating Board for Higher Education or the commissioner of higher education regarding programs submitted by independent institutions shall be recommendatory only.]

*[(10)]***(9)** General Review Criteria for New Degree and Certificate Programs.

(A) Mission and Planning Priorities.

1. The proposed new program must be consistent with the institutional mission, as well as the principal planning priorities of the **public** institution, as set forth in the **public** institution's approved plan or plan update *[in the case of public institutions or the institutional mission statement in the case of independent*

institutions].

2. The *[coordinating board shall]* **CBHE will** determine if proposed programs are consistent with a public institution's plan or plan update as approved by the *[coordinating board]* **CBHE**. Except in unusual circumstances, only those proposed new programs submitted by a public institution that are consistent with the institution's mission statement and, when appropriate, anticipated in its approved institutional plan, *[shall]* **will** be eligible for approval and implementation.

(B) Need for the Proposed Program.

1. *[There]* **Public institutions** shall *[be a]* clearly demonstrate*[d]* and *[well-]*document*[ed]* demand and/or need for the program in terms of meeting present and future needs of the locale and the state, although it is recognized that for program approval purposes state needs are a part of broader national needs. Three (3) kinds of needs may be identified—

A. Societal needs;

B. Occupational needs relative to upgrading vocational/technical skills or meeting labor market requirements; and

C. Student needs for a program.

2. Some programs may be desirable on the basis of their cultural contribution or social value or potential to serve student interests independent of labor market or demand considerations. However, in these instances the societal and student need for the program must be clearly demonstrated by the **public** institution submitting the proposal.

3. **Public** *[I]***i**nstitutions proposing new programs *[must present data projecting employment and student demands and availability of openings in the labor market to]* **at the routine level must certify that employment and student demands exist, are backed by compelling data, and will** be served by the new program. The kinds of information and data *[submitted]* **used** will vary somewhat with the type of program proposed but may include the following: personnel and employment projections prepared by the Bureau of Labor Statistics and the Missouri Occupational Information Coordinating Committee (MOICC) as well as professional and trade associations; surveys of potential employers, including numbers of anticipated vacancies and training requirements; and surveys of potential student interest.

4. Adequate data *[shall be provided to]* **should** support projections for the number of students who are expected to enter the program. Program enrollment *[shall]* **should** be sufficient to ensure a quality educational experience *[as well as an]* **and make** efficient *[utilization]* **use** of resources.

5. As an additional indicator of need, the **public** institution shall *[clearly detail]* **explain** how program success will be defined and measured, particularly if that definition includes measures in addition to the conferral of a degree or certificate.

6. Determination of need for a new program will be based in part upon an assessment of the function to be served by the program and the availability of alternative sources of education in a given service area. Availability of spaces in the same or similar programs in all institutions in the state offering postsecondary programs will be taken into account, as will possibilities for interinstitutional arrangements, including contracting as provided by statute.

(C) Duplication of the Proposed Program.

1. A **public institution's** proposed program shall not be unnecessarily duplicative of *[those of]* other Missouri institutions**' programs**. Ordinarily, proposed programs in basic liberal arts and sciences at the baccalaureate level would not be considered unnecessarily duplicative, provided sufficient student demand can be demonstrated. Unnecessary duplication is a more specific concern in graduate, technical**,** and professional programs which meet special labor market needs.

[2. The questions of how a proposed program meets an institution's local and state service area needs and how it articulates with appropriate baccalaureate or graduate programs shall also be addressed (In this context it is understood that some programs, for example, the AAS, are designed to be terminal in character and are not ordinarily expected to articulate with more advanced programs.)]

*[3.]***2.** *[Factors salient to the duplication issue include,]* **Unnecessary or inappropriate duplication will be determined by assessing the following factors** in descending order of priority*[,]***:** the relevance of existing programming; the availability of alternative educational delivery systems; the extent of student demand; state or regional work force demand; and access considerations such as geographic availability, student population served**,** and cost of instruction.

3. No public institution other than the University of Missouri and its campuses may offer a Ph.D. or professional practice doctorate (a.k.a. "first-professional degree") without CBHE approval pursuant to subsection (4)(C) of this rule.

A. All first-professional degree programs are closely regulated by recognized professional and specialized accrediting agencies. Some first-professional degrees require a prior degree, but this is not true of all. First-professional degrees include the following:

(I) Chiropractic (D.C. or D.C.M.)
(II) Dentistry (D.D.S. or D.M.D.)
(III) Law (L.L.B., J.D.)
(IV) Medicine (M.D.)
(V) Optometry (O.D.)
(VI) Osteopathic Medicine (D.O.)
(VII) Pharmacy (Pharm.D.)
(VIII) Podiatry (D.P.M., D.P., or Pod.D.)
(IX) Theology (M.Div., M.H.L., B.D., or Ordination)
(X) Veterinary Medicine (D.V.M.)

B. The Ph.D. in any discipline is generally recognized as a research degree, typically requiring completion of original research or evidence of artistic accomplishment. Ph.D. programs require unique faculty, student/faculty ratios, assigned teaching loads, and infrastructure and financial support.

[4. Determination of need for a new program will be based in part upon an assessment of the function to be served by the program and the availability of alternative sources of education in a given service area. Availability of spaces in the same or similar programs in all institutions in the state offering postsecondary programs will be taken into account, as will possibilities for interinstitutional arrangements, including contracting as provided by statute.]

(D) Program Structure.

1. Existing programs can be strengthened and enriched when appropriate new courses and certificate or degree programs are added to the curriculum. A proposed program should be based on existing strengths of the **public** institution rather than be composed entirely of new courses. Off-campus degree programs must be based on existing on-campus degree programs.

A. Normally, graduate programs should be built upon strong baccalaureate programs which can support advanced study through basic library holdings, faculty resources**,** and appropriate research facilities and funds. It is, however, recognized that some graduate programs in universities and medical schools do not require supporting undergraduate baccalaureate majors in that field.

B. New **public** institutions in the process of being established may also be considered exceptions to this general expectation, but special procedures have been established in this rule to accommodate the developing institution.

2. There *[shall]* **will** be a carefully planned and systematic program of study for the proposed program which is clear and comprehensive. The structure of a new program *[shall]* **must** take into account, and be demonstrably consistent with, program objectives and intended student learning outcomes.

A. The linkage between program requirements and anticipated learning outcomes shall be delineated. Required courses in the major *[shall]* **must** not be excessive and should be consistent with

customary expectations for the type of degree proposed.

B. The curriculum of the proposed program *[shall]* **must** reflect the requirements of any accrediting or certifying body if the **public** institution elects to apply for accreditation or certification. (This statement is not intended to imply that specialized accreditation should be an institutional goal.)

C. Unless necessary for accreditation or licensure, new baccalaureate degrees should consist of no more than one hundred twenty (120) semester credit hours and new associate degrees should consist of no more than sixty (60) semester credit hours.

3. Innovative programs of study shall also contain an orderly and identifiable sequence of education experiences that lead to a recognizable goal.

A. The awarding of credit for any experiential learning, credit by examination, off-campus courses, etc., shall be consistent with both established institutional and *[coordinating board]* **CBHE** policies. The requirements for off-campus programs *[shall]* **must** be fully comparable to those for similar on-campus programs. If these requirements are not the case for the proposed program, the rationale for the difference must be clearly explained.

B. The policies and procedures for granting experiential credit and/or credit by examination (including the maximum number of such credit hours which are applicable to a specific degree program and the minimum scores which are acceptable) *[shall]* **must** be clearly specified in written guidelines available to the student. The maximum number of experiential credit hours applicable to a specific degree program *[shall]* **must** be the same for students enrolled at off-campus locations as for students enrolled on-campus.

4. In general, courses offered for credit off-campus *[shall]* **must** be part of the regular catalogue offerings of the **public** institution and *[shall]* **must** be applicable to programs in the same manner as courses taken on-campus. Special courses developed solely for off-campus teaching *[shall]* **must** be limited and *[shall be]* consistent with the mission of the **public** institution. The standards for awarding credit to students enrolled at off-campus locations *[shall]* **must** be the same as the standards applied to students enrolled on campus.

5. Each **public** institution's policy concerning residency for academic study purposes (as distinct from fee level) *[shall]* **must** be stated clearly regarding the number of credit hours applicable to a degree program which must be earned in-residence on its campus and *[shall]* **must** explicitly define in-residence.

(E) Faculty Resources. Faculty resources *[shall]* **must** be appropriate for the program, given the sponsoring **public** institution's mission and the character of the program to be developed.

1. The minimum educational attainment of the faculty *[shall]* **must** be the appropriate degree and/or occupational or other equivalent experiences commensurate with the degree level of the proposed program. While the doctorate, in most instances, is the appropriate terminal degree for baccalaureate and graduate programs, the Master of Fine Arts (MFA) or a similar degree is often considered a terminal degree. If accreditation is a desired goal of the program, the number of terminal degree holders *[shall]* **must** meet the minimum requirements of the appropriate accrediting association.

2. Adjunct faculty are an important and necessary component of some programs, particularly those programs that require a high degree of vocational/technical competence. However, programs *[shall]* **must** involve credentialed full-time faculty in teaching, program development**,** and student services. If a program will involve more than fifty percent (50%) adjunct faculty, the rationale for the use of adjunct faculty *[shall]* **must** be documented and approved by the coordinating board or its designee.

3. Adjunct faculty, when utilized, *[shall]* **must** possess the same or equivalent qualifications as the regular faculty of the **public** institution and *[shall]* be approved by the academic unit through which the credit is offered. The responsibilities of adjunct faculty *[shall]* **will** be specified in such a manner that their involvement in program development and academic advising is assured, or that these activities are provided by other appropriate means.

4. Expected faculty workloads *[shall]* **must** be appropriate and consistent with good educational practice and expressed in student credit hours per full-time equivalent faculty member in the administrative unit that will support the proposed program. This information, of course, must be evaluated in the context of the sponsoring institution's mission, the mission of the proposed program**,** and the character of the discipline from which the proposed program is an outgrowth.

(F) Library Resources.

1. Qualitative and quantitative factors of library resources *[shall]* **must** be appropriate for the proposed program, given the sponsoring **public** institution's mission and the character of the program to be developed. Books, periodicals, microfilms, microfiche, monographs**,** and other collections *[shall]* **must** be sufficient in number, quality**,** and currency to serve the program. Adequacy of the library personnel and of facilities to service the proposed program in terms of students and faculty will be considered. While some technical programs may not demand the same type or extent of holdings and services conventional arts and science programs do, these factors must be adequate.

2. Access to interlibrary loans and to libraries at other institutions or in other cities *[shall]* **will** be indicated. Interlibrary loans and reciprocal loan privileges at local libraries may constitute valuable resources for the program. However, within this framework, adequate library material *[shall]* **must** be available at the **public** institution which proposes the program. If the program is to be taught off-campus, access to adequate library resources *[shall]* **must** be provided.

(G) Physical Facilities and Instructional Equipment. **The public institution shall provide** *[P]***p**hysical facilities and instructional equipment *[shall be]* adequate to support the program*[.]* **and** *[S]***s**pace*[s shall be provided]* for classrooms and for staff and faculty offices. Laboratories for studies in the technologies and sciences *[shall]* **must** be designed to provide maximum utilization of facilities, materials**,** and equipment*[. Some courses require laboratory facilities]*, **which may include** specialized equipment such as computer terminals and audiovisual aids, or other special resources. The **public** institution offering these courses off-campus *[shall]* **must** assure that appropriate support requirements are met.

(H) Administration and Evaluation.

1. Administration of the proposed programs *[shall]* **should** not be unduly cumbersome or costly*[.]* **and** *[I]***i**deally, *[the program should]* fit into the **public institution's** current administrative structure *[of the institution]*. If administrative changes are required, they *[shall]* **should** be consistent with the organization of the **public** institution as a whole and necessitate a minimum of additional expense in terms of personnel and office space.

2. Proposals for jointly sponsored programs *[shall]* **should** include *[provisions for]* adequate plans for cooperative administration.

3. Each **public** institution shall set forth not only the administrative organization but also the instructional supervision and evaluation procedures for the program. These procedures *[shall]* **must** include evaluation of courses and faculty by students, administrators**,** and departmental personnel. Curriculum review procedures established by each **public** institution for its program offerings *[shall]* **must** include standards and guidelines for the assessment of student outcomes as defined for the program and consistent with the institutional mission.

[4. The institution shall establish clearly defined performance goals for the new program to be achieved during a stipulated implementation period. The institution may revise its performance goals for the new program at any time during the designated implementation period with the concurrence of the CBHE staff.

5. The institution shall define a review process with the

concurrence of coordinating board staff to assess the program's development. In the event a new program fails to develop satisfactorily in the allotted period as determined by the commissioner, the status of the new program shall be evaluated. As a result of this review, approval may be continued with or without further stipulations, or program authorization may be withdrawn.]

*[6.]***4.** In the event that program authorization is withdrawn **or approval is denied**, if the sponsoring **public** institution chooses to continue the new program rather than terminate it, the resources associated with the program *[shall]* **will** be withdrawn from the **public** institution's funding base for the purpose of developing future state appropriation requests*[—]***.**

[7. Paragraphs(10)(H)4.—6. of this rule are not applicable to independent institutions.]

(I) Finances.

1. Suitable financing for initiating proposed programs must be available. Programs should be financed with fees from students new to the institution, funds that have been reallocated from institutional sources or grants, contracts or sources other than normal state appropriations for higher education.

2. In those circumstances for which one- (1-)*[-]* time or limited duration funds are an integral component of the financing arrangements for a new program, the institution must also define a transition plan for the period when the one- (1-)*[-]* time or limited duration funds cease to be available.

3. The proposed program may require phasing-out of some existing program(s) to reallocate institutional resources for new programs that are a logical outgrowth of existing **public** institutional strengths and consistent with the approved **public** institutional plan or plan update.

4. Ordinarily, approval will be extended only for those programs that meet these requirements unless the sponsoring **public** institution specifically requests additional state funds for program implementation. In this event, approval *[shall]* **will** be conditional on actual receipt of these funds through the legislative process.

[5. This subsection on finances is not applicable to independent institutions.]

*AUTHORITY: section[s 173.005(2), RSMo (1986) and] 173.030, RSMo [(Supp. 1988)] **2016, and section 173.055(2), RSMo Supp. 2018**. Original rule filed Feb. 13, 1979, effective June 18, 1979. Rescinded and readopted: Filed July 18, 1989, effective Oct. 15, 1989. Amended: Filed Oct. 22, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may submit a statement in support of or in opposition to this proposed amendment to the attention of Academic Affairs, Missouri Department of Higher Education, PO Box 1469, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED AMENDMENT

11 CSR 45-4.420 Occupational License. The commission is amending sections (2), (3), and (4).

PURPOSE: This amendment corrects references to the type of licensee referenced in section (2), and removes obsolete language from sections (3) and (4).

(2) Upon the filing of an application for an occupational license, the director may issue a temporary occupational license to allow an applicant to perform the function for which the applicant has applied. The director may withdraw or suspend this temporary occupational license by withdrawing the holder's occupational license badge upon a determination to seek denial of licensure by the commission and on so doing report this action to the commission, the Class *[A]* **B** licensee who employed the applicant, and the applicant.

(3) Upon issuance of an occupational license to applicant, applicant shall receive *[a partially completed]* **an** occupational license badge from the commission.

(4) Whenever an occupational license badge *[shall be]* **is** lost or destroyed, a duplicate occupational license badge in lieu of the lost or destroyed occupational license badge will be issued by the commission. The fee for a replacement occupational license badge is fifteen dollars ($15). Application for a duplicate occupational license badge shall be by affidavit of the licensee which shall set forth—

*AUTHORITY: sections 313.004, [and 313.850, RSMo 2000, and section] 313.800, **313.805, and 313.807,** RSMo [Supp. 2013] **2016**. Original rule filed May 13, 1998, effective Oct. 30, 1998. Amended: Filed Dec. 7, 2001, effective June 30, 2002. Amended: Filed Dec. 3, 2007, effective May 30, 2008. Amended: Filed Dec. 5, 2013, effective Aug. 30, 2014. Amended: Filed Nov. 1, 2018.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 7—Security and Surveillance

PROPOSED AMENDMENT

11 CSR 45-7.130 Nongambling Hours. The commission is amending section (1) and renumbering subsection (1)(B) as section (2).

PURPOSE: This amendment resolves a conflict with 11 CSR 45-9.113 regarding the surveillance requirement during nongambling hours.

[(1) Surveillance will be required during nongambling hours as follows:]

*[(A)]***(1)** *[Cleanup and Removal Time. Anytime cleanup operations or money removal is being conducted in the casino*

*area, a]***A**t least **two** (2) trained surveillance operators must be on duty *[and present]* in the casino surveillance room*[; and]* **actively monitoring activities during nongambling hours when no drops and counts are being conducted.**

*[(B)]***(2)** *[Locked-Down Mode.]* Anytime the casino is closed and in a locked-down mode, sufficient surveillance coverage as approved by the commission must be conducted to monitor and record the casino, in general, so that security integrity is maintained. *[During this period it is not required that a trained surveillance person be present.]*

*AUTHORITY: sections 313.004, 313.800, 313.805, and 313.824, RSMo [2000] **2016**. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. Amended: Filed Feb. 26, 2001, effective Sept. 30, 2001. Amended: Filed Nov. 1, 2018.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System

PROPOSED AMENDMENT

11 CSR 45-9.102 Minimum Internal Control Standards (MICS)—Chapter B. The commission is amending section (1).

*PURPOSE: This amendment changes the internal controls for Chapter B of the **Minimum Internal Control Standards** by clarifying requirements for sensitive keys.*

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter B—Key Controls, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter B does not incorporate any subsequent amendments or additions as adopted by the commission on *[February 23, 2011]* **October 31, 2018**.

*AUTHORITY: sections 313.004, [RSMo 2000 and sections] 313.800, and 313.805, RSMo [Supp. 2010] **2016**. Original rule filed Oct. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2018.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System

PROPOSED AMENDMENT

11 CSR 45-9.106 Minimum Internal Control Standards (MICS)—Chapter F. The commission is amending section (1).

*PURPOSE: This amendment changes the internal controls for Chapter F of the **Minimum Internal Control Standards** by removing unnecessary language and lessening staffing requirements for deck inspections.*

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter F—Poker Rooms, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter F does not incorporate any subsequent amendments or additions as adopted by the commission on *[July 30, 2014]* **October 31, 2018**.

*AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.800, 313.805, 313.812, 313.817, and 313.830, RSMo [Supp. 2014] **2016**. Original rule filed Jan. 26, 2012, effective Aug. 30, 2012. Amended: Filed Oct. 25, 2012, effective June 30, 2013. Amended: Filed March 28, 2013, effective Dec. 30, 2013. Amended: Filed July 31, 2014, effective Feb. 28, 2015. Amended: Filed Nov. 1, 2018.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System

PROPOSED AMENDMENT

11 CSR 45-9.109 Minimum Internal Control Standards (MICS)—Chapter I. The commission is amending section (1).

*PURPOSE: This amendment changes the internal controls for Chapter I of the **Minimum Internal Control Standards** by clarifying procedures for progressive jackpot meters and issuing player cards.*

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter I—Casino Accounting, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter I does not incorporate any subsequent amendments or additions as adopted by the commission on *[October 29, 2014]* **October 31, 2018**.

*AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.800, 313.805, 313.812, 313.817, and 313.830, RSMo [Supp. 2014] **2016**. Emergency rule filed July 31, 2014, effective Aug. 28, 2014, expired Feb. 26, 2015. Original rule filed July 31, 2014, effective Feb. 28, 2015. Amended: Filed Nov. 1, 2018.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System

PROPOSED AMENDMENT

11 CSR 45-9.116 Minimum Internal Control Standards (MICS)—Chapter P. The commission is amending section (1).

*PURPOSE: This amendment changes the internal controls for Chapter P of the **Minimum Internal Control Standards** by clarifying procedures for determining if an individual is an excluded person.*

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter P—Excluded Persons, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter P does not incorporate any subsequent amendments or additions as adopted by the commission on *[July 30, 2014]* **October 31, 2018**.

*AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.800, 313.805, 313.812, 313.817, and 313.830, RSMo [Supp. 2014] **2016**. Emergency rule filed July 31, 2014, effective Aug. 28, 2014, expired Feb. 26, 2015. Original rule filed July 31, 2014, effective Feb. 28, 2015. Amended: Filed Nov. 1, 2018.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System

PROPOSED AMENDMENT

11 CSR 45-9.117 Minimum Internal Control Standards (MICS)—Chapter Q. The commission is amending section (1).

*PURPOSE: This amendment changes the internal controls for Chapter Q of the **Minimum Internal Control Standards** by clarifying procedures for determining if an individual is a disassociated person.*

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter Q—Disassociated Persons, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter Q does not incorporate any subsequent amendments or additions as adopted by the commission on *[November 4, 2015]* **October 31, 2018**.

*AUTHORITY: sections 313.004, [RSMo 2000, sections] 313.800, **313.805,** 313.812, **313.813,** 313.817, and 313.830, [RSMo Supp. 2014, and sections 313.805 and 313.813,] RSMo [Supp. 2013] **2016**. Original rule filed Aug. 25, 2011, effective March 30, 2012. Emergency amendment filed July 31, 2014, effective Aug. 28, 2014, expired Feb. 26, 2015. Amended: Filed July 31, 2014, effective Feb. 28, 2015. Amended: Filed Nov. 4, 2015, effective June 30, 2016. Amended: Filed Nov. 1, 2018.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 30—Bingo

PROPOSED RESCISSION

11 CSR 45-30.020 Advertising. This rule clarified the amount of money licensees could use for advertising bingo operations pursuant to 313.040(9), RSMo.

PURPOSE: This rule is being rescinded to be consistent with the statutory change.

AUTHORITY: section 313.040, RSMo Supp. 2010 and section 313.065, RSMo 2000. Emergency rule filed June 21, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency rule filed Oct. 19, 1994, effective Oct. 29, 1994, expired Feb. 25, 1995. Original rule filed July 11, 1994, effective Jan. 29, 1995. Amended: Filed Dec. 14, 1998, effective July 30, 1999. Amended: Filed July 28, 2010, effective Jan. 30, 2011. Rescinded: Filed Nov. 1, 2018.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.030 Commission Approval of Procedures. The commission is deleting section (1), amending and renumbering sections (2) and (3), and renumbering each section thereafter.

PURPOSE: This amendment removes duplicative language and gives additional clarification in regard to submitting procedures.

[(1) Prior to operating in Missouri, each applicant for a Fantasy Sports Contest Operator (FSCO) License shall submit procedures to the commission that—

(A) Prevent unauthorized withdrawals from a registered player's account by the licensed operator or others;

(B) Make clear that funds in a registered player's account are not the property of the licensed operator and are not available to the licensed operator's creditors;

(C) Segregate player funds from operational funds;

(D) Maintain a reserve in the form of cash or cash equivalents in the amount of the deposits made to the accounts of fantasy sports contest players for the benefit and protection of the funds held in such accounts;

(E) Ensure any prize won by a registered player from participating in a fantasy sports contest is deposited into the registered player's account within forty-eight (48) hours of winning the prize;

(F) Ensure registered players can withdraw the funds maintained in their individual accounts, whether such accounts are open or closed, within five (5) business days of the request being made, unless the licensed operator believes in good faith that the registered player engaged in either fraudulent conduct or other conduct that would put the licensed operator in violation of sections 313.900 to 313.955, RSMo, in which case the licensed operator may decline to honor the request for withdrawal for a reasonable investigatory period until its investigation is resolved if it provides notice of the nature of the investigation to the registered player. For the purposes of this provision, a request for withdrawal will be considered honored if it is processed by the licensed operator but delayed by a payment processor, credit card issuer, or by the custodian of a financial account;

(G) Allow a registered player to permanently close their account at any time for any reason; and

(H) Offer registered players access to their play history and account details.]

[(2)] **(1) For all procedures required by statute to be approved by the commission** *[E]*each applicant shall submit the written description of its procedures and all supporting documents designed to satisfy the requirements *[of section (1)]* of *[this rule]* **Chapter 313, RSMo** to the commission with the initial application, unless otherwise directed by the commission.

*[(3)]***(2)** The commission shall review each submission required by *[section (2) of this rule and]* Chapter 313, RSMo, and shall determine *[whether it conforms to the requirements of section (1) of this rule and]* whether the procedures submitted satisfy the requirements. If the commission finds any insufficiencies, they shall be specified in writing to the licensee, who shall make appropriate alterations. No FSCO license shall be issued unless and until the procedures are approved by the commission.

*[(4)]***(3)** Once approved, no licensed operator shall alter its procedures unless and until the change is approved by the commission.

*[(5)]***(4)** Each licensed operator shall submit to the commission any change to the approved procedures no less than fifteen (15) days prior to the planned implementation date of the change. The proposed change to the procedures shall be approved or disapproved by the commission. Upon approval, the change may be implemented. If the change is disapproved, the licensed operator shall not implement the change.

*[(6)]***(5)** If at any time the commission determines that a licensed operator's procedures are inadequate or do not comply with the requirements of this chapter or Chapter 313, RSMo, the commission shall notify the licensed operator in writing. Within fifteen (15) days after receiving the notification, the licensed operator shall amend its procedures accordingly and shall submit a copy of the procedures, as amended, and a description of any other remedial measures taken.

*[(7)]***(6)** If a licensed operator plans to disseminate the List of Disassociated Persons (DAP List), the operator shall submit to the commission a plan for the dissemination of the information regarding persons placed on the DAP List, as well as persons who have been removed from the DAP List. The plan shall be designed to safeguard, as best as is reasonably possible, the confidentiality of the information but shall include dissemination to at least the personnel responsible for removing a person on the DAP List from all individually targeted advertising or marketing. Licensed operators may not disclose the name of, or any information about, a person who has been placed on or removed from the DAP List to anyone other than

employees and agents of the licensed operator whose duties and functions require access to the information. The plan must be approved by the commission prior to disseminating the information. All information disclosed to any licensed operator regarding anyone placed on or removed from the DAP List shall be deemed a closed record; however, the information may be disclosed as authorized by the individual seeking placement on the DAP List, by law, and through the provisions contained in 11 CSR 45-17.

AUTHORITY: sections 313.915, 313.920, 313.950, and 313.955, RSMo 2016. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Nov. 1, 2018.

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.100 Special License Plates. The department is amending sections (1)–(2) and (5)–(8), deleting section (11), and renumbering as necessary.

PURPOSE: This rule is being amended to add local and beyond local 24,000 lb. special license plate categories, update an outdated statutory reference, and remove unnecessary language.

(1) For the purpose of this rule, "special license plates" *[shall]* includes all personalized, military, collegiate, helping schools, and special organizational license plates that contain letters and/or numbers and may include one apostrophe (’), one space, or one dash (—).

(2) All special license plates are available in the following plate categories—

(I) Local and Beyond Local 24;

*[(I)]***(J)** Shuttle Bus—regular personalized plates only;

*[(J)]***(K)** Van Pool—regular personalized plates only; and

*[(K)]***(L)** Historic—regular personalized plates only.

(5) Special license plates *[shall]* **will** not be transferred from one (1) owner to another unless provided by law, except that the holder of a special plate may follow the procedures established by the director in order to display his/her special plate on a vehicle leased by the holder after approval by the director; and they *[shall]* **will** not be transferred from one (1) vehicle category to another. This includes any request for transfer by gift, trust, will, or judicial proceeding.

(6) The director of revenue *[shall]* reserves the right to approve or disapprove any request for special license plates or the transfer of license plates from one (1) vehicle to another in the same category.

(7) *[The month of expiration on all special license plates for motorcycles and motortricycles will be April of each year.]* Special license plates issued to members of the United States Congress, Missouri State Senate, and Missouri House of Representatives; honorary consulars; and the following statewide elected officials: governor, lieutenant governor, secretary of state, state auditor, state treasurer, and attorney general, which are issued in accordance with section *[301.144]* **301.453**, RSMo, will expire in January of each year. *[The month of expiration on all other special license plates issued or renewed prior to January 1, 2009, shall be staggered. Special license plates issued or renewed on or after January 1, 2009, shall expire as detailed in the chart below.]* **Passenger, RV, 6,000 and 12,000 lb. Commercial Motor Vehicle (CMV), Shuttle Bus, Van Pool, and Personalized Historic special license plates will expire in July of each year.** Registrations for special license plates will be issued for a minimum of six (6) months except as otherwise determined by the director. Applicants who purchase a biennial registration will extend the registration another year with the total registration not to exceed thirty (30) months.

[SPECIAL LICENSE PLATE CATEGORY	*EXPIRATION MONTH*
Governor, Lieutenant Governor, Secretary of State, State Auditor, State Treasurer, Attorney General, United States Congress, Missouri State Senate, Missouri House of Representatives, and Honorary Consulars	*January*
Passenger, RV, 6,000 and 12,000 lb. Commercial Motor Vehicle (CMV), Shuttle Bus, Van Pool, Personalized Historic	*July*
Motorcycle/tricycle	*April*
18,000 lb. and above CMV	*December]*

(8) Initial applications for special license plates *[shall]* **will** be made on *[Form 1716, Application For Missouri Personalized And Special License Plates, or Form 4601, Application For Missouri Military Personalized License Plates, respectively. The Application For Missouri Personalized And Special License Plates, revised October 2008 and Application For Missouri Military Personalized License Plates, revised July 2008, both of which are incorporated by reference, are published by and can be obtained from the Missouri Department of Revenue, PO Box 43, Jefferson City, MO 65105-0043 or at http://dor.mo.gov/mvdl/motorv/forms/. These applications do not include any amendments or additions to their October 2008 and July 2008 editions respectively. Initial applications must be submitted to the Department of Revenue, PO Box 569, Jefferson City, MO 65105-0569]* **appropriate forms and accompanied by any special license plate fee and additional documentation as required by law**. *[Applications shall be accompanied by a special license plate fee of fifteen dollars ($15), and a current emblem-use authorization statement or proof of military service, if required by law.]*

[(11) Reapplications (renewals) for special license plates shall be filed with the Department of Revenue prior to the last day of the month in which they expire.]

*[(12)]***(11)** The director of revenue may recall any special license plate erroneously issued under this rule.

AUTHORITY: sections 301.144 [and 301.451], [RSMo Supp. 2008 and section] 301.449, ***and 301.453,*** *RSMo [2000]* ***2016, and section 301.130, RSMo Supp. 2018****. Original rule filed Aug. 14, 1978, effective Nov. 13, 1978. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Oct. 25, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.260 Inspection of *[Foreign Motor]* ***Non-USA Standard*** **Vehicles Prior to Titling**. The department is amending the title, revising section (2), and removing the image of form 551 herein.

PURPOSE: This rule is being amended to remove the image of form 551.

(2) Some motor vehicles which are purchased by Missouri residents in another country and imported into the United States are manufactured for importation into the United States and conform to all legal standards. The ownership document for these vehicles is usually a Manufacturer's Statement of Origin similar to the type issued for a motor vehicle constructed by an American manufacturer.

(A) Any application for title to a motor vehicle imported into the United States which is accompanied by a Manufacturer's Statement of Origin need not be accompanied by a DOR Form 551*[(B)]*. If problems are encountered at the time the application is entered into the Department of Revenue's computer, the central office will inform the applicant to contact the Missouri State Highway Patrol to request that they inspect the vehicle and complete a Vehicle Examination Certificate.

AUTHORITY: section 301.190, RSMo [1986] ***2016****. Original rule filed March 21, 1986, effective July 11, 1986. Amended: Filed Oct. 25, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.280 Replacement of Multiyear License Plates. The department is amending sections (1) and (2).

PURPOSE: This amendment is to update the life span reference to license plates and remove language mandating the applicant keep the same configuration.

(1) In January 1979 the Department of Revenue began issuing multiyear license plates. The categories of multiyear license plates are: passenger; recreational vehicle; motorcycle; motortricycle; commercial motor vehicles licensed as Local (L) 6000 and 12,000, Beyond Local (BL) 9000, BL 6000**,** and 12,000; shuttle bus; and van pool. These license plates were subjected to manufacturing processes**,** which guarantee a minimum useful life of *[five (5)]* **six (6)** years. Holders of multiyear license plates issued at least *[five (5)]* **six (6)** years previously may be issued new license plates upon the payment of the annual registration (renewal) fee subject to the procedures outlined that follow:

(C) If the owner of multiyear license plates requests new license plates upon renewal, but declares that s/he cannot surrender his/her old license plates because they were lost, stolen**,** or destroyed, the applicant must complete an application for replacement plates and pay the appropriate replacement plate *[charge]* **fee** in addition to the regular registration fee. The applicant **may be issued new license plates from the office's current inventory stock. Upon request, applicant** will be issued validation tabs from the current inventory stock and a replacement permit and receipt. The replacement plates will be manufactured with the same configuration as the original plates and will be mailed to the applicant. The applicant will affix the new validation tabs to the replacement plates when they are received by him/her;

(D) If the owner of multiyear license plates requests new plates at any time other than during the month of renewal because the license plates currently on the vehicle are at least *[five (5)]* **six (6)** years old, s/he may be issued replacement plates at no fee*[; however, the applicant must]* **upon** surrender **of** the damaged license plates. The applicant **may be issued new license plates from the office's current inventory stock. Upon request, owner** will be issued replacement tabs and a replacement permit and receipt. The replacement plates will be manufactured with the same configuration as the original plates and mailed to the applicant;

(E) If the owner of multiyear license plates**,** which are at least *[five (5)]* **six (6)** years old, purchases another vehicle and does not wish to transfer the license plates, the applicant may pay the appropriate transfer fee, surrender the old plates and be issued replacement plates at no fee. The applicant will be issued replacement tabs, a replacement permit and receipt. The replacement plates will be manufactured with the same configuration as the original plates and mailed to the applicant;

(F) If the owner of multiyear license plates, which are at least *[five (5)]* **six (6)** years old, purchases another vehicle but does not wish to transfer the old license plates and refuses to surrender them, s/he may be issued a new set of license plates from the *[branch or fee agent]* office's current inventory stock*[. S/he will be required to]* **upon** pay**ment of** the appropriate registration fee and the failure to transfer fee; and

(G) If the owner of multiyear license plates, which are at least *[five (5)]* **six (6)** years old, has only one (1) license plate to surrender and declares the other license plate was lost, stolen**,** or destroyed, s/he may be issued a new set of multiyear license plates under the procedures established in subsection (1)(A) of this rule. The applicant will not be required to pay the failure to renew fee or apply for one (1) replacement plate.

(2) An owner of multiyear license plates, which are less than *[five (5)]* **six (6)** years old, who either refuses to renew or to transfer the plates will be issued new plates, be charged the appropriate renewal fee**,** and be charged either a failure to renew or failure to transfer fee, whichever is applicable.

*AUTHORITY: section 301.130, RSMo [1986] **Supp. 2018**. Original rule filed April 21, 1986, effective Aug. 11, 1986. Amended: Filed Oct. 25, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.340 Imposition and Waiver of Motor Vehicle and Trailer Titling and Registration Penalties. The department is amending section (1) and the authority section.

PURPOSE: This rule is being amended to update and correct language and conform to the twenty-four thousand pound (24,000 lb.) special license plate rule amendment at 12 CSR 10-23.100.

(1) The department *[shall]* assess**es** penalties on three (3) types of motor vehicle and trailer titling and registration transactions. These penalties are—a delinquent registration renewal penalty, a failure to title penalty**,** and a failure to renew or transfer a multiyear license plate penalty. All penalties may be waived by the department under certain circumstances.

(A) Delinquent Registration Renewal Penalty. If an owner of a multiyear license plate submits his/her application for renewal on the first day of the month following the month of expiration of the license plate, a delinquent registration renewal penalty *[shall]* **will** be assessed. If the last day of the month of expiration falls on a Saturday, Sunday**,** or legal state holiday, the following state working day is penalty free. If, for example, an owner has November license plates and the last day of November falls on Sunday, **then** Monday, December 1 would be considered penalty free for all November renewals.

1. Once a motor vehicle is registered for use on Missouri highways, it is subject to *[annual]* registration **renewal**. The motor vehicle **registration** is to be *[registered annually]* **renewed** whether or not it is actually on or off the highways for any period of time. This obligation to *[register the vehicle annually]* **renew the registration** continues until the owner ceases to operate the vehicle on Missouri highways, at which time s/he is required to return his/her license plates to the director of revenue within ninety (90) days. If an owner of a motor vehicle surrenders his/her license plates to an office of the Department of Revenue within the ninety**-** (90-)*[-]* day period after ceasing to operate the motor vehicle, s/he may register

that same vehicle again at a later date *[(see subparagraphs (1)(A)1.A.–C.)]* without being subject to a delinquent registration renewal penalty.

A. If an owner elects to renew the registration of a vehicle which s/he has ceased operating anytime during the twelve**-** (12-)*[-]* month period following the expiration of the license plates, s/he will be issued the appropriate license plate and validation tabs and be charged the appropriate twelve**-** (12-)*[-]* month registration fee. A delinquent registration renewal penalty *[shall]* **will** not be charged provided the owner submits the receipt documenting his/her surrender of previously issued license plates.

B. An owner's registration *[shall]* **will** be automatically cancelled after one (1) year from the date of expiration of a Missouri license plate. If an owner elects to cease operation of his/her vehicle, and the license plates on the vehicle have been expired for at least one (1) year, the owner will not be required to pay a delinquent registration renewal penalty if s/he elects to relicense the vehicle after one (1) year from the date of expiration of the license plates.

(B) Failure to Title Penalty. If a purchaser of a motor vehicle or trailer fails to make application for a certificate of ownership within thirty (30) days after acquiring a motor vehicle or trailer, the department *[shall]* assess**es** the title penalty set by law for each thirty (30)-day period of delinquency, not to exceed the maximum penalty allowed. The first penalty fee shall be assessed on the 31st day of delinquency. If the 30th, 60th, 90th, 120th, 150th, 180th, 210th, 240th or the 270th day of delinquency falls on a Saturday, Sunday**,** or legal state holiday, the penalty fee *[shall]* **will** not be imposed on the next state working day. If, for example, an individual purchases a motor vehicle on August 1, and the 30th day of the first period of delinquency falls on Sunday, August 31, the first penalty would not be imposed on Monday, September 1 but on Tuesday, September 2.

(C) Penalty for Failure to Renew or Transfer a Multiyear License Plate. A penalty fee *[shall]* **will** be imposed on any applicant who elects not to renew or transfer a multiyear license plate. Multiyear license plates are issued to— passenger vehicles; recreational vehicles; motorcycles; motortricycles; commercial motor vehicles registered for Local (L) *[6,000, L 12,000,]* **and** Beyond Local (BL) 6**,**000*[, BL 9000 and BL 12,000]* **to 24,000**; shuttle buses; and van pool vehicles. If an applicant does not renew the multiyear license plates currently registered to his/her vehicle, but requests that new multiyear license plates be issued, a penalty fee *[shall]* **will** not be imposed provided the applicant changes license plate categories. For example, if the applicant has regular passenger license plates and requests disabled person license plates, no failure to renew or transfer penalty *[shall]* **will** be imposed.

*AUTHORITY: section[s 301.050, RSMo 1986 301.190 and 301.300] **301.130**, RSMo Supp. [1990] **2018**. Original rule filed July 30, 1986, effective Nov. 28, 1986. Amended: Filed Oct. 25, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.345 Definition of Major Component Parts of a Motor Vehicle. The department is amending section (1), adding section (2), and removing the image herein.

PURPOSE: This rule is being amended to update language, add major component part(s) for motorcycles, and remove the associated image therein.

(1) The seven (7) major component parts which are commonly used to reconstruct a motor vehicle *[shall be]* **are** defined solely for reconstruction purposes as follows*[. The written definition of each major component part is further clarified by an artist's drawing]*:

(E) Cowl—The sheet metal formed by severing the vehicle across the floor in the vicinity of the front seat and severing the windshield posts. It does not include parts forward of the firewall. If a cowl is included as an integrated part of a front clip, front-end assembly**,** or rear clip, it *[shall]* **will** not be considered a major component part for the purpose of determining the total number of the major component parts used in the reconstruction of a motor vehicle;

(2) The major component parts which are commonly used to reconstruct a motorcycle are defined solely for reconstruction purposes as follows:

(A) Frame; and

(B) Transmission.

*AUTHORITY: section 301.010, RSMo Supp. [1989] **2018**. Original rule filed Sept. 1, 1986, effective Nov. 28, 1986. Amended: Filed Oct. 25, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.350 Honorary Consular License Plates. The department is amending sections (1)–(7) and (9)–(13) and removing sections (14)–(16).

PURPOSE: This rule is being amended to update language and remove outdated information.

(1) Under the authority of the Foreign Missions Act, 22 U.S.C. Section 4301, the Office of Foreign Missions of the United States

Department of State *[has begun]* issu*[ing]***es** a *[new]* series of motor vehicle license plates for vehicles owned by foreign missions and their authorized representatives. These *[new]* federal license plates replace and supersede the special diplomatic and consular plates formerly issued by the various states including Missouri. The *[new]* law also provides for federal titling of vehicles owned by foreign missions and their authorized representatives.

(2) The *[new]* federal license plates are issued to the following categories of personnel:

(3) The *[new]* federal license plates are easily recognizable, being painted red, white**,** and blue, are the standard six inches by twelve inches (6" × 12") in size**,** and bear the words Issued by the United States Department of State at the bottom.

(4) In accordance with the Foreign Missions Act, 22 U.S.C. Section 4301, the United States Department of State has directed that license plates issued by any state, including Missouri, to honorary consuls must contain words, symbols**,** and colors that are clearly distinguishable from the federal plates. Furthermore, each state has been requested to refrain from embossing the words, CONSULAR OFFICER on the license plates *[issued by the states]*. This procedure should assist law enforcement agencies in determining if the license plate displayed on a motor vehicle is a federal- or state-issued **license** plate. Missouri may not issue license plates to any motor vehicle which is required to be registered with the federal government.

(5) Honorary consuls are defined as United States nationals or permanent residents who are appointed as honorary consular officers of foreign missions. The United States Department of State has notified Missouri that honorary consuls will not be permitted to register their vehicles under the federal program. However, honorary consuls are authorized under section 26.140, RSMo to use Missouri motor vehicle license plates which identify them as honorary consular officers. Accordingly, the director of revenue has established a category of specialized personalized license plates for issuance to honorary consuls patterned after the provisions of section 301.144*[.2.]*, RSMo.

(6) Honorary consular license plates *[shall]* consist of white letters and numerals on a royal blue field. The configuration of these plates *[shall]* consist of the letter C followed by a dash and the numerals one through and including sixty-six (1–66). At the bottom of the royal blue field *[shall]* appear the words HON. CONSUL in the place of Show Me State.

(7) No more than one (1) set of two (2) honorary consular license plates *[shall]* **will** be issued to a qualified applicant.

(9) Honorary consular license plates *[shall]* **will** only be issued to passenger motor vehicles subject to the registration fees provided in section 301.055, RSMo.

(10) Applicants for honorary consular license plates *[shall be]* **are** required to comply with all Missouri laws and rules relating to the taxing, titling, registration**,** and safety inspection of motor vehicles.

(11) Any person desiring to obtain a set of two (2) honorary consular license plates *[must]* **will** make application and *[shall]* pay a*[n annual]* personalized plate fee of fifteen dollars ($15) in addition to the regular registration fees for passenger vehicles as detailed in section 301.055, RSMo. Initial application for honorary consular license plates *[shall be]* **are** submitted to the Department of Revenue, Motor Vehicle Bureau, P*[.]*O*[.]* Box 100, Jefferson City, MO 65105 and *[shall]* be accompanied by the personalized plate fee, *[a paid personal property tax receipt of the previous calendar year or a statement of nonassessment for the same period, a vehicle safety/emissions inspection not more than sixty (60) days old, a statement certifying proof of insurance]* **any other documents required by law to obtain registration,** and a copy of the honorary consular officer identification card issued by the Missouri secretary of state. Upon approval, honorary consular license plates will be issued *[by the Motor Vehicle Bureau]*. Subsequent annual renewals may be accomplished at any *[branch or fee agent]* **license** office statewide where the renewing applicant will be issued universal registration renewal tabs.

(12) Prior to the receipt of honorary consular license plates, the applicant *[must]* **is to** surrender all previously issued license plates which bear the words Consular Officer and pay any additional fees due. If no consular officer plates were issued, the applicant *[must]* **is to** surrender the regular license plates which the honorary consular license plates will replace. If the honorary consular license plates are to be issued for a period of less than one (1) full year, the department *[shall]* **will** assess registration fees on a prorated basis. No refunds *[shall]* **are to** be made for any unused portion of registration fees for any license plates surrendered in exchange for honorary consular license plates.

(13) Applications for renewal of honorary consular license plates *[shall]* **will** be filed with the Department of Revenue prior to the last regular work day of January each year. All plates annually expire on January 31.

[(14) According to the United States Department of State, honorary consular officers who have been issued license plates identifying them as honorary consuls are not entitled to diplomatic immunity from any state, county or municipal parking or traffic laws or from arrest or detention for violation of those laws.

(15) According to the United States Department of State, honorary consuls are not exempt from any taxes whatsoever, including county or City of St. Louis personal property tax, state sales or use taxes, or local sales taxes. No tax exemption shall be granted in connection with any application for honorary consular license plates unless exempt status is certified to the department by the United States Department of State for each proposed transaction.

(16) On January 1, 1987, all consular officer license plates previously issued by the Missouri Department of Revenue which bear the words Consular Officer and which have white lettering on a red field shall become invalid.]

*AUTHORITY: sections 26.140 [and]**,** 301.135, [RSMo 1986] and 301.144, RSMo [Supp. 1989]* ***2016****. Original rule filed Oct. 3, 1986, effective Dec. 26, 1986. Emergency amendment filed Oct. 30, 1989, effective Nov. 9, 1989, expired March 8, 1990. Amended: Filed Oct. 30, 1989, effective Feb. 25, 1990. Amended: Filed Oct. 25, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.370 Issuance of Certificates of Title to Recreational Vehicles Manufactured by Two Separate Manufacturers. The department is amending sections (1)–(2).

PURPOSE: This rule is being amended to update information and language and replace a definition of "motor home" with a definition of "recreational motor vehicle."

(1) When recreational vehicles or *[motor homes]* **recreational motor vehicle** are manufactured by separate manufacturers and have separate and distinct Manufacturers' Statements of Origin (MSO) issued for the unit, the following titling procedures *[shall]* apply:

(2) For the purpose of this rule, *[motor home]* **a recreational motor vehicle** shall be defined as *[a new vehicular unit, designed to provide temporary living quarters, built into as an integral part of, or permanently attached to a self-propelled motor vehicle chassis or van]* **any motor vehicle designed, constructed, or substantially modified so that it may be used and is used for the purposes of temporary housing quarters, including therein sleeping and eating facilities which are either permanently attached to the motor vehicle or attached to a unit which is securely attached to the motor vehicle**. The vehicle must contain permanently installed independent life support systems which meet the American National Standards Institute/National Fire Protection Association (ANSI/NFPA) 501C Standard and provide at least four (4) of the following facilities: cooking, refrigeration or ice box, self-contained toilet, heating or air conditioning, or both, a portable water supply system including a faucet and sink, separate one hundred ten to one hundred twenty-five (110–125)-volt electrical power supply or a liquefied petroleum (LP) gas supply or both. The basic types are specified as follows:

*AUTHORITY: sections [301.010,] 301.190 and 301.200, RSMo [2000] **2016, and section 301.010, RSMo Supp. 2018**. Original rule filed Dec. 2, 1986, effective March 12, 1987. Amended: Filed June 24, 2003, effective Dec. 30, 2003. Amended: Filed Oct. 25, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.405 Emblem-Use Authorization Statement and Format for Collegiate License Plates. The department is amending sections (1)–(3), deleting subsections (2)(A) and (B) and section (4), and amending and renumbering as necessary.

PURPOSE: This rule amendment is to update out of date references and fix consistency issues.

(1) Any community college or four- (4-)*[-]* year public or private institution of higher education**, or a foundation or organization representing the college or institution,** located in Missouri authorizing the use of its official emblem to be affixed to a license plate annually *[must]* **will** issue an emblem-use authorization statement. The statement *[must]* **will** be *[on a form prescribed]* **in a format agreed upon** by the director of the Department of Revenue and *[must]* **which** includes the name of the community college or four-(4-)*[-]* year public or private institution, the applicant's name and address, the amount of *[fee]* **contribution** paid**,** and the date of payment.

(2) One (1) emblem-use authorization statement *[must]* **needs to** be issued for each collegiate license plate application. *[A statement issued prior to July 1 of any calendar year shall be accepted for applications for collegiate license plates with an expiration month of the upcoming October, with the exception of collegiate license plates issued during the first year of issuance (1990). In this case, statements dated prior to July 1, 1991 will be accepted for applications for collegiate license plates with an expiration in October, 1991. Statements issued after the last day of June of any calendar year will be accepted for applications for collegiate license plates to be issued or renewed in the coming October with an expiration month of the next succeeding October.]*

[(A) Example One: Emblem-use authorization statements dated before July 1, 1991 will result in issuance or renewal of collegiate license plates which expire in October 1991.

(B) Example Two: Emblem-use authorization statements dated after July 1, 1991 and before June 30, 1992 will result in issuance or renewal of collegiate license plates which expire in October 1992.]

(3) Any community college or four- (4-)*[-]* year public or private institution of higher education which desires to have license plates issued which display its emblem, logo**,** or seal must *[issue four hundred fifty (450) emblem-use authorization statements]* **submit two-hundred (200) applications** before the Department of Revenue will authorize the manufacture of license plates displaying its emblem, logo**,** or seal.

[(4) Should the community college or four (4)- year public or private institution of higher education be unable to issue four hundred fifty (450) emblem-use authorization statements, the institution must establish a mechanism for refunding the contributions to the applicant for these statements in the event refunds are requested by the applicant. Refunds shall only be made in the event the minimum number of emblem-use authorization statements are not issued.]

*[(5)]***(4)** Any community college or four- (4-)*[-]* year public or private institution of higher education *[which]* desir*[es]***ing** to have collegiate license plates issued *[must]* **should** submit a preliminary design of the emblem, logo**,** or seal which it desires to be displayed upon the license plates as well as school colors that need to be included. This design *[must]* **will** be formatted in accordance with the design of the plate as prescribed in section *[(6)]* **(5)** of this rule. The department will submit the design to the vendor for the material to manufacture the plates. The vendor will prepare the finished artwork for the emblem, logo or seal and submit it to the Department of Revenue and the appropriate institution for approval. Upon approval, the department will authorize the manufacture of the

plates*[, provided the community college or four (4)-year public or private institution of higher education has issued the required minimum number of emblem-use authorization statements and has notified the Department of Revenue in writing that the required minimum number of emblem-use authorization statements have been issued to applicants]*.

*[(6)]***(5)** *[On the top of the collegiate license plate shall appear the words OCT and MO.]* The left-hand portion of the plate will bear a reproduction of the college emblem, seal**,** or logo in an area not to exceed two and one-half inches by three inches (2 1/2" × 3"). Immediately to the right of the emblem, seal**,** or logo, *[shall]* **will** appear one to five (1–5) characters. The bottom of the license plate *[shall]* **will** bear the name of the community college or public or private institution of higher education, in lieu of SHOW ME STATE, in an area not to exceed eleven inches by one inch (11" × 1").

*AUTHORITY: section 301.449, RSMo [Supp. 1990] **2016**. Original rule filed Nov. 1, 1989, effective Feb. 25, 1990. Amended: Filed Oct. 25, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.424 Leasing Company Registration. The department is amending sections (3), (5), and (6).

PURPOSE: This amendment provides for issuing leasing company registrations on a staggered basis to equalize the Department of Revenue's workload.

(3) *[Renewal applications for registration as a leasing company shall be filed with the director prior to December 1 of each registration period. Leasing company registrations shall expire on December 31 of each registration period.]* **The director may stagger expiration dates to equalize workload.** Leasing companies with expired registrations *[shall]* **will** not be entitled to the sales tax option provided by section 144.070, RSMo, *[but shall]* **and will** pay all state and local sales tax on the purchase price of any units acquired while the registration is expired.

(5) Any transfer of a motor vehicle, trailer, boat**,** or outboard motor to another division from one (1) division of a corporation which authorizes a division to register as a motor vehicle leasing company *[shall be]* **is** a sale at retail as defined in section 144.010, RSMo.

(6) The director *[shall]* **will** deny application for, or recall any permit to operate as a leasing company, if the applicant—

(A) Has fraudulently completed the application for registration;

(B) No longer holds a valid Missouri sales tax license; or

(C) Is no longer properly registered with the Office of the Missouri Secretary of State.

*AUTHORITY: sections 144.010, [RSMo Supp. 2003 and] 144.070, **and 144.270,** RSMo [2000] **2016**. Emergency rule filed Oct. 28, 1991, effective Nov. 7, 1991, expired March 6, 1992. Emergency rule filed Feb. 26, 1992, effective March 7, 1992, expired July 5, 1992. Original rule filed Oct. 28, 1991, effective May 14, 1992. Amended: Filed Oct. 10, 2003, effective April 30, 2004. Amended: Filed Oct. 25, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 26—Dealer Licensure

PROPOSED AMENDMENT

12 CSR 10-26.080 Procedural Requirements For Public Motor Vehicle Auctions. The department is amending sections (4)–(13), deleting section (3), and renumbering as needed.

PURPOSE: This rule amendment is to remove unnecessary information and update an outdated internet reference.

[(3) Each auction shall provide access to all records requested by Department of Revenue employees or law enforcement during normal business hours.]

*[(4)]***(3)** *[Motor vehicles shall only be sold at an auction conducted by a licensed auctioneer.]* The motor vehicle auction must be scheduled and publicized at least one (1) week prior to the sale date.

*[(5)]***(4)** Any individual conducting a public motor vehicle auction must be licensed pursuant to all applicable laws and make available for inspection all applicable licenses to law officers or Department of Revenue employees. An auction shall maintain a record of each individual performing auctioneering services and the inclusive dates of such services.

*[(6)]***(5)** Prior to selling any motor vehicle at auction, an auction shall review all applicable vehicle documentation**,** including but not limited to**,** the following: certificate of title and odometer disclosure statement, if applicable.

(A) Prior to selling a vehicle at auction, the auctioneer must announce any brands printed on the title, the condition of the vehicle, any known damage to the vehicle, the odometer reading of the vehicle**,** and any other information on the odometer disclosure statement.

*[(7)]***(6)** *[Motor vehicles sold at auction are not required to be safety inspected.]* Auctioneers shall announce at the beginning of each public auction that the vehicles offered for sale may not have

been safety inspected. *[Relevant signs shall be posted as required by statute.]*

*[(8)]***(7)** Both licensed dealers and the public may attend and buy or sell at a public motor vehicle auction.

*[(9)]***(8)** Motor vehicle auctions shall not accept for sale from a dealer any vehicle without a Federal Buyer's Guide affixed to the vehicle or which does not comply with other applicable state or federal disclosure requirements.

*[(10)]***(9)** An auction must verify that each dealer who sells at the auction is currently licensed as a motor vehicle dealer in the state of Missouri or another jurisdiction.

*[(11)]***(10)** A certificate of number (license) issued to an auction by the director must be prominently displayed at the auction's bona fide established place of business. A separate license must be obtained by each public motor vehicle auction.

*[(12)]***(11)** An auction may only conduct business at its licensed location. Off-site sales are prohibited.

*[(13)]***(12)** An auction must issue to the buyer and seller of each vehicle a document that contains—

(A) The year, make, model**,** and vehicle identification number of the motor vehicle;

(B) The name and address of the seller;

(C) The name and address of the buyer;

(D) The date of sale and the purchase price; and

(E) The odometer reading of the motor vehicle at the time of sale.

*AUTHORITY: sections 301.550[-301.573] **to 301.580**, RSMo [1994 and Supp. 1998] **2016 and RSMo Supp. 2018**. Original rule filed Nov. 1, 1999, effective May 30, 2000. Amended: Filed Oct. 25, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 26—Dealer Licensure

PROPOSED AMENDMENT

12 CSR 10-26.180 Temporary Permits Sold by a Registered Missouri Motor Vehicle Dealer. The department is amending section (4).

PURPOSE: This rule amendment increases a three- (3-) year period to five (5) years, in which certain temporary permit records are to be maintained.

(4) Upon each sale of a temporary permit, each dealer shall fully complete all information on the temporary permit in accordance with Department of Revenue instructions *[and complete all appropriate records of issuance found within the booklet of permits]*. If the permit is issued pursuant to a courtesy delivery arrangement, the dealer issuing the permit must record the words courtesy delivery on the corresponding permit *[and on the permit record within the permit booklet]*. The information listed shall be true, accurate**,** and complete. Temporary permits that are spoiled shall be marked void and kept as a part of the dealership's records. *[The]* **Temporary permit** records shall be maintained *[in booklet form]* for a period of at least *[three (3)]* **five (5)** years for inspection by law enforcement or Department of Revenue officials.

*AUTHORITY: section[s 301.140 and] 307.380, RSMo [2000] **2016, and section 301.140, RSMo Supp. 2018**. This rule previously filed as 12 CSR 10-23.190. Original rule filed Oct. 1, 1985, effective Dec. 26, 1985. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 25, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 26—Dealer Licensure

PROPOSED AMENDMENT

12 CSR 10-26.190 Dealers' Monthly Reports. The department is amending sections (1)–(2) and (4)–(5).

PURPOSE: This rule amendment requires dealers filing electronic sales reports to continue filing electronically and to file reports in months when they have zero (0) sales. The amendment also removes unnecessary information.

(1) Every motor vehicle and boat dealer must file a monthly sales report on a form prescribed by the director of revenue in accordance with section 301.280, RSMo. This report shall be completed in full and *[actually]* received by the Department of Revenue on or before the fifteenth day of the month following the month for which the sales are being reported. (Example: Sales occurring during the month of July must be filed on or before August 15.)

[(B) If any monthly sales report required to be filed on or before a prescribed date is delivered after that date by United States mail, postage prepaid and addressed to the Department of Revenue, the date of the United States postmark stamped on the envelope shall be deemed to be the date of filing. Official United States postmarks will suffice as proof of mailing. Reports may also be submitted by certified mail, registered mail or the dealer may obtain a validated certificate of mailing or receipt from the United States Post Office to establish date of mailing.]

(2) *[If no sales occur in any given month, a report must be submitted for that month indicating no sales.]* **Every motor vehicle and boat dealer filing sales reports electronically in accordance with section 301.280, RSMo shall continue to file reports**

electronically even when monthly sale amounts do not meet the minimum amounts required to file electronically.

(4) Every motor vehicle and boat dealer shall retain copies of the sales reports *[submitted to the Department of Revenue as part of the records to be maintained at the dealership location as provided in section 301.560.1, RSMo]* and shall hold them available for inspection by appropriate law enforcement officials, and officials of the Department of Revenue.

(5) Every motor vehicle dealer shall submit *[the original blue]* **a** copy of the secure power of attorney form *[(see 12 CSR 10-23.420)]* in which the dealer is listed as purchaser and a copy of the corresponding certificate of title with the dealer's monthly sales reports as provided in 12 CSR 10-23.420.

*AUTHORITY: sections 32.057 and 301.280, RSMo [2000] **2016,** and **section** 301.560[.1], RSMo Supp. [2003] **2018**. This rule previously filed as 12 CSR 10-23.050. Original rule filed April 14, 1980, effective Sept. 12, 1980. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 25, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 41—General Tax Provisions

PROPOSED AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The Director of Revenue proposes to amend section (1) to reflect the interest to be charged on unpaid, delinquent taxes.

PURPOSE: This proposed amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2019.

(1) Pursuant to section 32.065, RSMo, the Director of Revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governor*[']*s of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set**,** by administrative order**,** the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%
2017	4%
2018	4%
2019	**5%**

*AUTHORITY: section 32.065, RSMo 2016. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 22, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 22, 2018.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate. This proposed amendment will result in an increase in the interest rate charged on delinquent taxes.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate. Although the 2019 interest rate imposed on delinquent taxes is one percent (1%) higher than the rate imposed in 2018. The actual number of affected taxpayers is unknown. See detailed fiscal note for further explanation.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Counties	*This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate. This proposed amendment will result in an increase in the interest rate charged on delinquent taxes.*
Cities	
Special Taxing Districts	

III. WORKSHEET

The proposed amendment adjusts the rate of interest for fiscal year 2020 to five percent (5%), an increase of one percent over the rate in 2018.

The future amount of past due taxes is unknown. Although the 2019 interest rate imposed on delinquent taxes is one percent higher than the rate imposed in 2018. This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 4.00%	**Proposed Amendment 5.00%**
Past due tax amount	$100.00	$100.00
Interest Amount (%)	x 4.00	x 5.00
Total Amount Due	**$104.00**	**$105.00**

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2018 was 5 percent.

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	**Classification by types of the business entities which would likely be affected:**	**Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:**
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	*This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.* Although the 2019 interest rate imposed on delinquent taxes is one percent higher than the rate imposed in 2018. *The actual number of affected taxpayers is unknown. See detailed fiscal note for further explanation.*

III. WORKSHEET

The proposed amendment adjusts the rate of interest for fiscal year 2020 to five percent (5%), an increase of one percent over the rate in 2018.

This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate. Although the 2019 interest rate imposed on delinquent taxes is one percent higher than the rate imposed in 2018. The actual number of affected taxpayers is unknown.

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Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2018 was 5 percent.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 34—Homeless, Dependent and Neglected Children

PROPOSED AMENDMENT

13 CSR 35-34.080 Children's Income Disbursement System (KIDS). The division is amending sections (2), (3), (5), (6), (7), and (8).

PURPOSE: This amendment updates policy and practice regarding funds distributed into the Children's Income Disbursement System for youth in the custody of Children's Division.

(2) When a child is placed in the legal custody of the Children's Division (CD) under Chapter 211, RSMo, the CD shall establish an account to receive and hold *[any]* money received by the division on behalf of the child. *[All m]***M**onies received by a child in the custody of the CD shall be processed through the Children's Services Income Disbursement System (KIDS)*[, also known as the Alternative Care Trust Fund]*.

(B) The funds received *[must]* **may** be applied toward the care of the child prior to authorizing payment from state or federal funds for the child's care.

(C) These funds shall be received by the Division of *[Budget and Finance (DBF)]* **Finance and Administrative Services (DFAS)** for deposit with a financial institution and *[disbursement in the Alternative Care Trust Fund and]* accounted for in the name of the child **in the Children's Income Disbursement System (KIDS)**.

(3) *[All m]***M**oney received on behalf of the child shall be processed through *[DBF]* **the Division of Finance and Administrative Services**.

(A) The director of the Children's Division shall **apply to** be *[designated as]* **the** payee for any independent source of benefits for children in the care and custody of CD.

(B) Once the child's KIDS account has been established, the payer shall be instructed to send the income directly to *[DBF]* **DFAS** who will enter the funds into the KIDS account.

(C) Any **Social Security or Veteran's Administration (VA)** monies received by the county office for deposit in a child's KIDS account must be registered on the appropriate form and sent to *[DBF]* **DFAS** for deposit into the KIDS account. **Any child support money received in the county office for deposit must be sent to the Child Support Financial Resolutions Section prior to deposit.**

[(D) Each Children's Division circuit manager shall designate a three (3) person monitoring team of three (3) CD employees within the circuit to monitor the KIDS accounts for children within that circuit to assure program integrity.]

(5) The division may accept funds which a parent, guardian**,** or other person voluntarily wishes to provide for the use and benefit of the child. The use and deposit of such funds shall be governed by 210.560, RSMo and any additional directions given by the provider of the funds.

(A) *[Any m]***M**onies received voluntarily from any parent, guardian**,** or other person on behalf of a child for deposit in the child's *[KIDS]* account shall be disbursed as provided in section (4) of this rule unless the person providing the funds furnishes specific, clear written instructions at the time that the funds are provided directing how the funds shall be used. The division shall keep the instructions with the child's records as provided in section (6) below. If the division is unable to disburse the funds in the manner provided in the written instructions, or if the written instructions are unclear, the division shall provide written notice to the person provides the funds and request further written instructions regarding disbursement of the funds. If the division does not receive written instructions within thirty (30) days of the date that the notice is given, the division may, at the division's discretion, disburse the funds as provided in section (4) of this rule or refund the balance of monies provided to the person providing the funds.

(6) A copy of all forms, statements**,** and information on each child's *[KIDS]* account shall be maintained with child's records for *[six (6)]* **five (5)** years after the child's case is closed.

(7) When a child leaves alternative care, the CD shall contact *[the Family Support Division (FSD), Financial Management and Operational Services Section (FM and OS)]* **the FACES Payment Unit**, for the determination of prior expenses which should be paid from the KIDS account. *[FSD (FM and OS)]* **The FACES Payment Unit** shall determine prior expenses for five (5) years prior to the date the child left alternative care pursuant to section 516.120, RSMo. *[FSD (FM and OS)]* **The FACES Payment Unit** will process prior expenses to be paid from the KIDS account through fund recoupments for payments made on behalf of the child.

(8) The division shall furnish an annual, itemized statement *[to the child and the child's guardian ad litem]* listing all transactions involving the funds which have been deposited or disbursed on the child's behalf from the **child's** account **to the child's guardian *ad litem***. The statements and supporting documentation shall be open to inspection to the guardian *[ad litem]* ***ad litem*** and the child.

AUTHORITY: sections [210.560] ***207.020 and 660.017****, RSMo [2000]* ***2016****. Original rule filed Oct. 7, 2005, effective April 30, 2006. Amended: Filed Oct. 17, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 94—Rural Health Clinic Program

PROPOSED AMENDMENT

13 CSR 70-94.010 Independent Rural Health Clinic Program. The division is amending sections (4), (5), (7), and (8), removing sections (9), (10), and (12), and renumbering section (11).

PURPOSE: This rule is being amended to reflect the current cost report form and related worksheets, provide an exemption to the cost report filing requirements, and to clarify documentation and record retention requirements, interim payments, and final settlements.

(4) Definitions. The following definitions shall apply for the purpose of this rule:

(E) Medicaid cost report. The documents used*[,]* for the purpose of reporting the cost of rendering both covered and non-covered services for the facility's fiscal year*[,]* shall be the Medicare cost report forms *[(HCFA-222 (3/83))]* **CMS-222-92** and all worksheets supplied by

the division**. If the Medicare CMS-222-92 is superseded by an alternate Medicare developed cost reporting tool during a facility's fiscal year, that tool must be used for the facility's fiscal year**; and

(5) Administrative Actions.

(A) Annual Cost Report.

1. Each independent RHC shall complete a Medicaid cost report for the RHC's twelve**-** (12-)*[-]* month fiscal period.

2. Each RHC is required to complete and submit to the division an Annual Cost Report, including all worksheets, attachments, schedules, and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

A. An independent RHC may be exempt from filing a Medicaid cost report if there is no MO HealthNet reimbursement for the reporting period and the facility does not plan to bill the MO HealthNet program for any claims for the reporting period. The facility must submit a request to the division to waive the cost report filing requirement within five (5) calendar months after the close of the facility's reporting period. To request an exemption for the cost report filing requirement, the following information must be submitted to MHD for review and approval:

(I) A Low or No Missouri Medicaid Utilization Waiver Request Form. This form may be obtained from the division. The form must be fully completed and signed by an officer or administrator; and

(II) Worksheet S series of the Medicare Cost Report. The applicable parts of the Worksheet S must be completed and signed by an officer or administrator.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this rule.

4. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. *[A single]* **An** extension*[, not to exceed thirty (30) days,]* may be granted upon the request of the RHC and the approval of the division **with an agreed upon date of completion**. The request must be received in writing by the division prior to the end of the five (5) calendar-month period after the close of the reporting period.

5. In a change of ownership, the cost report for the closing period must be submitted within forty-five (45) calendar days of the effective date of the change of ownership, unless the change in ownership coincides with the seller's fiscal year end, in which case the cost report must be submitted within five (5) months after the close of the reporting period. No extensions in the submitting of cost reports shall be granted when a change in ownership has occurred.

6. Cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the prescribed period, except as expressly extended in writing by the state agency, may result in the imposition of sanctions as described in 13 CSR 70-3.030.

7. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to MO HealthNet participants must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following:

A. Audit, review, or compilation statement prepared by an independent accountant, including disclosure statements and management letter;

B. Contracts or agreements involving the purchase of facilities or equipment during the **past** five (5) years if requested by the division, the department, or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Schedule detailing all grants, gifts, and income from endowments, including amounts, restrictions, and use;

F. Documentation of expenditures, by line item, made under all restricted and unrestricted grants, gifts, or endowments;

G. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

H. Leases or rental agreements, or both, related to the activities of the provider;

I. Management contracts;

J. Provider of service contracts; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

8. Under no circumstance will the division accept amended cost reports for final settlement determination or adjustment after the date of the division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the division or its authorized agent for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

C. Records of related organization, as defined by 42 CFR 413.17, must be available upon demand.

D. The division shall retain all uniform cost reports submitted **by the independent RHCs** for *[a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record-keeping requirements of 42 CFR 413.20]* **seven (7) years after the final settlement relating to a cost report is finalized, including the resolution of any subsequent appeals or other administrative actions pertaining to the cost report**.

E. Each facility shall retain all financial information, data, and records relating to the operation and reimbursement of the facility for *[a period of not less than five (5) years]* **seven (7) years after the final settlement relating to a cost report is finalized, including the resolution of any subsequent appeals or other administrative actions pertaining to the cost report, and will maintain those reports pursuant to the record-keeping requirements of 42 CFR 413.20**.

2. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the RHC does not maintain records that provide an adequate basis to determine payments under MO HealthNet.

B. The suspension or reduction continues until the RHC demonstrates to the division's satisfaction that it does, and will continue to, maintain adequate records.

(7) Interim Payments.

(B) An independent RHC *[in]* **contracted with** a MO HealthNet managed care *[region]* **health plan** shall be eligible for supplemental reimbursement up to its interim Medicare RHC rate. *[This]* **The supplemental** reimbursement shall make up the difference between **what the independent RHC would have been paid by the division based on** the independent RHC's Medicare rate and **the** total managed care health plan payments **made** to the clinic **during the reporting period** for *[managed care participants for]* covered services rendered to MO HealthNet managed care participants *[during the reporting period]* **as set forth in the Managed Care contract**. The supplemental reimbursement shall occur pursuant to the schedule agreed to by the division and the independent RHC but shall occur no less frequently than every four (4) months. Supplemental reimbursement shall be requested **by the independent RHC** on forms provided by the division. Supplemental reimbursement for

managed care charges shall be considered interim reimbursement of the independent RHC's MO HealthNet costs.

(8) *[Reconciliation]* **Final Settlement**.

(A) **Final Settlement Determination.** The state agency shall perform an annual desk review of the Medicaid cost reports for each RHC's fiscal year and shall make *[indicated]* **the necessary payment** adjustments *[of]* **(i.e., an** additional payment or **a** recoupment**)**, in order that the RHC's net reimbursement shall equal reasonable costs as described in this section.

1. The total reimbursement amount due the RHC for covered services furnished to MO HealthNet participants is based on the **allowable costs from the** Medicaid cost report and is calculated as follows:

A. The average cost per visit is calculated by dividing the total allowable cost incurred for the reporting period by total visits for RHC services furnished during this period. The average cost per visit is subject to tests of reasonableness which may be established in accordance with this rule or incorporated in the Allowable Cost per visit as determined on Worksheet *[3.A., line 7]* **C, Part I, line 9 of the cost report**.

B. The total cost of RHC services furnished to MO HealthNet participants is calculated by multiplying the allowable cost per visit by the number of MO HealthNet visits for covered RHC services.

2. The total reimbursable cost is compared *[with total payments and third party liability made to the RHC for the reporting period.]* **to the total interim payments made to the RHC during the reporting period for MO HealthNet participants to determine the amount of the final settlement owed to or due from the RHC. The total interim payments include the amount paid by the division as determined from the division's MMIS reports, the health plan payments as set forth in the Managed Care contract, and third party liability payments.**

3. The total reimbursement will be subject to adjustment based on the results of a field audit which may be conducted by the MO HealthNet Division or its contracted agents.

(B) *[Notice of Program Reimbursement]* **Notification of Final Settlement**.

1. The division will notify the RHC by letter of a cost report final settlement after the division completes the desk review of the cost report. The division's notification letter will include the calculation of the final settlement and a Settlement Agreement, which the facility will sign and return to the division indicating it agrees with the final settlement calculation. The division**'s** *[shall send]* written notice to the RHC *[of]* **shall indicate if the final settlement results in** the following:

*[1.]***A.** Underpayments. If the total reimbursement due the RHC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the RHC to bring total *[interim]* payments into agreement with total reimbursement due the RHC; and

*[2.]***B.** Overpayments. If the total interim payments made to a RHC for the reporting period exceed the total reimbursement due the RHC for the period, the division arranges with the RHC for repayment *[through a lump sum refund, or, if that poses a hardship for the RHC, through]* **of the overpayment either by having it** offset against **the RHC's** subsequent interim payments**, having the RHC repay by sending the division a payment,** or a combination of offset and *[refund]* **payment**.

2. The RHC shall review the division's notification letter and attachments and respond with a signed Settlement Agreement indicating it has accepted the final settlement within fifteen (15) calendar days of receiving the final settlement letter. If the RHC believes revisions to the division's desk review and final settlement are necessary before it can accept the settlement, it must submit additional, amended, or corrected data within the fifteen- (15-) day deadline. Data received from the RHC after the fifteen- (15-) day deadline may not be considered by the division in determining if revisions to the final settlement are needed unless the RHC requests and receives an extension for submitting additional information prior to the end of the fifteen- (15-) day deadline. If the fifteen- (15-) day deadline passes without a response from the provider, the division will proceed with processing the final settlement as set forth in the division's notification letter, and the final settlement shall be deemed final. The division may not accept an amended cost report or any other additional information to revise the cost report or final settlement after the final settlement is finalized.

[(9) Sanctions.

(A) The division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the MO HealthNet program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(10) Appeals. In accordance with sections 208.156 and 621.055, RSMo, providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the MO HealthNet Division.]

*[(11)]***(9)** Payment Assurance.

(A) The state will pay each RHC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the RHC according to the standards and methods set forth in the regulations implementing the RHC Reimbursement Program.

(B) RHC services provided for those participants having available Medicare benefits shall be reimbursed by MO HealthNet to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, MO HealthNet will be the payer of last resort.

(D) Regardless of changes of ownership, management, control, leasehold interests by whatever form for any RHC previously certified for participation in the MO HealthNet program, the division will continue to make all the Title XIX payments directly to the entity with the RHC's current provider number and hold the entity with the current provider number responsible for all MO HealthNet liabilities.

[(12) Payment in Full. Participation in the MO HealthNet program shall be limited to providers who accept as payment in full, for covered services rendered to MO HealthNet participants, the amount paid in accordance with these rules and applicable copayments.]

AUTHORITY: sections 208.201 ***and 660.017****, RSMo [Supp. 2007]* ***2016****. Emergency rule filed Aug. 20, 1993, effective Sept. 18, 1993, expired Jan. 15, 1994. Emergency rule filed Jan. 19, 1994, effective Jan. 29, 1994, expired Jan. 31, 1994. Original rule filed Aug. 20, 1993, effective Jan. 31, 1994. Amended: Filed Aug. 15, 2008, effective Feb. 28, 2009. Amended: Filed Oct. 17, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the

Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 110—Division of Youth Services
Chapter 3—*[Aftercare Responsibilities]* *Case Management*

PROPOSED AMENDMENT

13 CSR 110-3.030 Aftercare Supervision. The division is amending the chapter title and all sections.

PURPOSE: This amendment changes the chapter title and removes sections (2) and (3) as they are covered in other regulations and division policies. It amends section (4) to change the terminology of Foster Care to Alternative Care Givers in order to draw a distinction between it and the Children's Division's Foster Care Program. It also amends outdated terminology and removes repetitive language.

(1) Community Placement. *[It is the responsibility of the service coordinator to provide]* **The Division of Youth Services will ensure the appropriate** treatment services **are in place** for the *[client]* **youth** and his/her family.

[(2) Case Recordings. The service coordinator shall maintain the following records:

(A) A record of dates and type of contacts made on each youth; and

(B) A monthly summary will be prepared for each youth. The summary will include the date and times of contacts as well as client progress and future planning and

(C) It is mandatory that each six (6) months an evaluation be completed on all youth committed to the Division of Youth Services (DYS).

(3) Transfers. Transfer of an aftercare case shall be made as follows:

(A) To Interstate. (see 13 CSR 110-2.130(2));

(B) Transfers between regions must be approved by the two (2) regional administrators involved; and

(C) To Other Agencies. Transfers to other agencies will be coordinated through the special services administrator.]

*[(4)]***(2)** *[Foster Care]* **Placement with Alternative Caregivers**. Except in cases of emergency, children under Division of Youth Services supervision and placed in *[foster]* **alternative caregiver** homes funded by DYS shall be so placed only after an evaluation of the home has been completed. This evaluation shall include, but not be limited to, the adequacy of the home, family stability and composition**,** and the motivation and ability of the *[foster parents]* **alternative caregivers** to provide *[foster]* care. **An alternative caregiver may be a relative or a person who is not related to the youth but has a close relationship with the youth or the youth's family.**

(A) Preparation for Placement. *[It is the responsibility of the service coordinator to]* **The Division of Youth Services shall** prepare the family and the youth for the impending placement. That preparation may include, but not be limited to, the following:

1. Counseling and training with the *[foster family]* **alternative caregivers**;

2. Preplacement visits between the *[child]* **youth** and the *[foster family]* **alternative caregivers**;

3. Explanation of agency rates of payment and guidelines for expenditures of money *[in]* **on** the *[foster child's]* **youth's** behalf;

4. Evaluation of any other income the *[child]* **youth** might have, such as Social Security benefits, Veteran's Administration benefits, etc., as well as the youth's family's financial situation. The applicability of these funds to the *[child's]* **youth's** needs will be determined by the regional administrator; **and**

5. Discussion of arrangement for payment of special needs, such as, medical expenses, educational**,** or therapeutic, etc.*[; and]*

[6. All foster homes will be approved prior to the child's placement by the regional administrator. All foster home placements will be approved by the regional administrator.

(B) Services to Family and Youth. The service coordinator will provide services to the youth and foster family as well as the youth's family.]

*[(5)]***(3)** Contractual **Residential** Services. *[The need for the services will be determined by the regional administrator prior to the placement of a youth. The regional administrator will ensure that funds are available.]* **The Division of Youth Services may utilize contractual residential services when it determines that the youth's needs are beyond the scope of services available at a Division of Youth Services' operated facility or space is not available at a Division of Youth Services' facility in close proximity to the youth's home or family.**

*[(6)]***(4)** Return to Facility (Shelter). A temporary return of the youth in aftercare to the *[institutional]* facility for reasonable cause may be permitted upon the recommendation of the service coordinator with the approval of the regional administrator. Reasonable cause is to be determined only upon the basis of need for alternative placement with none immediately available. *[Where]* **When** the youth is returned for shelter, every effort is to be made by the service coordinator to complete alternate placement plans within thirty (30) days. *[A report will be submitted each week that the youth is in shelter over thirty (30) days. The report will be submitted to the regional administrator justifying the continued need for shelter and outlining plans for alternative arrangements with a copy to the facility providing shelter.]* **Shelter placements may extend beyond 30 days with approval by the regional administrator.** When a placement is established by the service coordinator, *[s/he]* **the service coordinator** will notify the facility and make arrangements for the youth to be released with the approval of *[his/her]* **the service coordinator's** supervisor.

*[(7)]***(5)** Return to Facility (*[Sanction]* **Revocation**). Procedure for the return of youths held in violation of the conditions of aftercare supervision is outlined in 13 CSR 110-3.040 *[and 13 CSR 110-3.050]*.

*[(8)]***(6)** Discharges from Aftercare Supervision. Section 219.026, RSMo *[1994]***,** requires the division to immediately notify in writing the youth, his/her parent**(s)** or guardian**(s)**, victim's rights respondent**,** and the committing court of the termination of its supervision over the youth.

AUTHORITY: sections ***219.016,*** *219.036,* ***and 660.017,*** *RSMo [1994]* ***2016****. Original rule filed Dec. 30, 1975, effective Jan. 9, 1976. Amended: Filed Feb. 10, 2000, effective Aug. 30, 2000. Amended: Filed Oct. 30, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the

Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 1—Controlled Substances

EMERGENCY AMENDMENT

19 CSR 30-1.002 Schedules of Controlled Substances. The department is amending section (1) Schedules of Controlled Substances.

PURPOSE: This emergency amendment updates the list of all drugs falling within the purview of controlled substances to match the corresponding list promulgated by the Drug Enforcement Administration (DEA).

(1) Schedules of Controlled Substances.

(A) Schedule I shall consist of the drugs and other substances*[,]* by whatever official name, common or usual name, chemical name or brand name designated*[,]* listed in this section. Each drug or substance has been assigned the Drug Enforcement Administration (DEA) Controlled Substances Code Number set forth opposite it.

1. Opiates. Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

A. Acetyl-alpha-methylfentanyl (*[N]N*-(1-(1-methyl-2-phenethyl)-4-piperidinyl)-*[N]N*-phenylacetamide) 9815

B. Acetylmethadol 9601

C. Acetyl fentanyl (*N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide) 9821

*[C.]***D.** AH-7921(3,4-dichloro-*[N]N*-[(1-dimethylamino) cyclohexylmethyl] benzamide) 9551

*[D.]***E.** Allylprodine 9602

*[E.]***F.** Alphacetylmethadol (except levoalphacetylmethadol also known as levo-alpha-acetylmethadol levothadyl acetate or LAAM) 9603

*[F.]***G.** Alphameprodine 9604

*[G.]***H.** Alphamethadol 9605

*[H.]***I.** Alpha-methylfentanyl (*[N]N*-1-(alphamethyl-beta-phenyl) ethyl-4-piperidyl) propionanilide; 1-(1-methyl-2-phenylethyl)-4 ((*[N]N*-propanilido) piperidine) 9814

*[I.]***J.** Alpha-methylthiofentanyl (*[N]N*-(1-methyl-2-(2-thienyl) ethyl-4-piperidinyl)-*[N]N*-phenylpropanamide) 9832

*[J.]***K.** Benzethidine 9606

*[K.]***L.** Betacetylmethadol 9607

*[L.]***M.** Beta-hydroxyfentanyl (*[N]N*-(1-(2-hydroxy-2-phenethyl)-4-piperidinyl)-*[N]N*-phenylpropanamide) 9830

*[M.]***N.** Beta-hydroxy-3-methylfentanyl (*[o]***O**ther name: *[N]N*-(1-(2-hydroxy-2-phenethyl)-3-methyl-4-piperidinyl)-*[N]N*-phenylpropanamide*[)]***;** 9831

*[N.]***O.** Betameprodine 9608

*[O.]***P.** Betamethadol 9609

*[P.]***Q.** Betaprodine 9611

*[Q.]***R.** Clonitazene 9612

*[R.]***S.** Dextromoramide 9613

*[S.]***T.** Diampromide 9615

*[T.]***U.** Diethylthiambutene 9616

*[U.]***V.** Difenoxin 9168

*[V.]***W.** Dimenoxadol 9617

*[W.]***X.** Dimepheptanol 9618

*[X.]***Y.** Dimethylthiambutene 9619

*[Y.]***Z.** Dioxaphetyl butyrate 9621

*[Z.]***AA.** Dipipanone 9622

*[AA.]***BB.** Ethylmethylthiambutene 9623

*[BB.]***CC.** Etonitazene 9624

*[CC.]***DD.** Etoxeridine 9625

*[DD.]***EE.** Furethidine 9626

*[EE.]***FF.** Hydroxypethidine 9627

*[FF.]***GG.** Ketobemidone 9628

*[GG.]***HH.** Levomoramide 9629

*[HH.]***II.** Levophenacylmorphan 9631

*[II.]***JJ.** 3-Methylfentanyl *[(N]N-[(([*3-methyl-1-(2-phenylethyl)-4-piperidyl)-*[N]N*-phenylproanamide), its optical and geometric isomers, salts, and salts of isomers 9813

*[JJ.]***KK.** 3-Methylthiofentanyl (*[N]N-[(]*(3-methyl-1-(2-thienyl)ethyl-4-piperidinyl*[)]*-*[N]N*-phenylpropanamide) 9833

*[KK.]***LL.** Morpheridine 9632

*[LL.]***MM.** MPPP (1-methyl-4-phenyl-4-propionoxypiperidine) 9661

NN. MT–45 (1-cyclohexyl-4-(1,2-diphenylethyl) piperazine) (9560)

*[MM.]***OO.** Noracymethadol 9633

*[NN.]***PP.** Norlevorphanol 9634

*[OO.]***QQ.** Normethadone 9635

*[PP.]***RR.** Norpipanone 9636

*[QQ.]***SS**. Para-fluorofentanyl*[(N]-N*-(4-fluorophenyl)-*[N]N-[(]*1-(2-phenethyl)-4-piperidinyl*[)]* propanamide 9812

*[RR.]***TT.** PEPAP (1-(-2-phenethyl)-4-phenyl-4-acetoxypiperidine) 9663

*[SS.]***UU.** Phenadoxone 9637

*[TT.]***VV.** Phenampromide 9638

*[UU.]***WW.** Phenomorphan 9647

*[VV.]***XX.** Phenoperidine 9641

*[WW.]***YY.** Piritramide 9642

*[XX.]***ZZ.** Proheptazine 9643

*[YY.]***AAA.** Properidine 9644

*[ZZ.]***BBB.** Propiram 9649

*[AAA.]***CCC.** Racemoramide 9645

*[BBB.]***DDD.** Thiofentany *[(N]-N*-phenyl-*[N]N*-(1-(2-thienyl)ethyl-4-piperidinyl)-propanamide 9835

*[CCC.]***EEE.** Tilidine 9750

*[DDD.]***FFF.** Trimeperidine 9646

2. Opium derivatives. Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Acetorphine 9319

B. Acetyldihydrocodeine 9051

C. Benzylmorphine 9052

D. Codeine methylbromide 9070

E. Codeine-*[N]N*-Oxide 9053

F. Cyprenorphine 9054

G. Desomorphine 9055

H. Dihydromorphine 9145

I. Drotebanol 9335

J. Etorphine (except hydrochloride salt) 9056

K. Heroin 9200

L. Hydromorphinol 9301

M. Methyldesorphine 9302

N. Methyldihydromorphine 9304
O. Morphine methylbromide 9305
P. Morphine methylsulfonate 9306
Q. Morphine-N-Oxide 9307
R. Myrophine 9308
S. Nicocodeine 9309
T. Nicomorphine 9312
U. Normorphine 9313
V. Pholcodine 9314
W. Thebacon 9315

3. Opiate similar synthetic substances. Substances scheduled by the United States Drug Enforcement Administration as substances that share a pharmacological profile similar to fentanyl, morphine, and other synthetic opioids, unless specifically excepted or unless listed in another schedule. These substances are:

A. Butyryl fentanyl (*N*-(1-phenethylpiperidin-4-yl)-*N*-phenylbutyramide) 9822
B. U–47700 (3,4-Dichloro-*N*-[2-(dimethylamino) cyclohexyl]-*N*-methyl benzamide) 9547

*[3.]***4.** Hallucinogenic substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture**,** or preparation, which contains any quantity of the following hallucinogenic substances or which contains any of its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (For purposes of paragraph (1)(A)*[3.]***4.** of this rule only, the term isomer includes the optical, position**,** and geometric isomers.):

A. Alpha-ethyltryptamine 7249
Some trade or other names: etryptamine; Monase; alpha-ethyl-1*[H]H*-indole-3-ethenamine; 3-(2-aminobutyl)indole; alpha-ET; and AET;

B. 4-bromo-2,5-dimethoxyamphetamine 7391
Some trade or other names: 4-bromo-2, 5-dimethoxy-a-methylphenethylamine; 4-bromo-2, 5-DMA;

C. 4-bromo-2,5-dimethoxyphenethylamine 7392

D. 2,5-dimethoxyamphetamine 7396
Some trade or other names: 2,5-dimethoxy-amethylphenethylamine; 2,5-DMA;

E. 2,5-dimethoxy-4-ethylamphetamine 7399
Some trade or other names: DOET**;**

F. 2,5-dimethoxy-4-(n)-propylthiophenethylamine 7348
*[(o)***O**ther name: 2C-T-7*[)]***;**

G. 2-(2,5-Dimethoxy-4-(n)-propylphenyl) ethanamine (2C-P) 7524

H. 2-(2,5-Dimethoxy-4-ethylphenyl) ethanamine (2C-E) 7509

I. 2-(2,5-Dimethoxy-4-methylphenyl) ethanamine (2C-D) 7508

J. 2-(2,5-Dimethoxy-4-nitro-phenyl) ethanamine (2C-N) 7521

K. 2-(2,5-Dimethoxyphenyl) ethanamine (2C-H) 7517

L. 2-(4-Chloro-2,5-dimethoxyphenyl) ethanamine (2C-C) 7519

M. 2-(4-Ethylthio-2,5-dimethoxyphenyl) ethanamine (2C-T-2) 7385

N. 2-(4-Iodo-2,5-dimethoxyphenyl) ethanamine (2C-I) 7518

O. 2-(4-Isopropylthio)-2,5-dimethoxyphenyl) ethanamine (2C-T-4) 7532

P. 4-methoxyamphetamine 7411
Some trade or other names: 4-methoxy-amethylphenethylamine; paramethoxyamphetamine; PMA;

Q. 5-methoxy-3,4-methylenedioxyamphetamine 7401

R. 4-methyl-2,5-dimethoxyamphetamine 7395
Some trade and other names: 4-methyl-2, 5-dimethoxy-a-methylphenethylamine; DOM; and STP;

S. 3,4-methylenedioxyamphetamine 7400

T. 3,4-methylenedioxymetham-phetamine (MDMA) 7405

U. 3,4-methylenedioxy-*[N]N*-ethylamphetamine (also known as *[N]N*-ethylalpha-methyl-3,4 (methylenedioxy) phenethylamine, *[N]N*-ethyl MDA, MDE**,** and MDEA) 7404

V. N-hydroxy-3,4-methylenedioxyamphetamine (also known as *[N]N*-hydroxy-alpha-methyl-3,4 (methylenedioxy) phenethylamine and *[N]N*-hydroxy MDA) 7402

W. 3,4,5-trimethoxyamphetamine 7390

X. 5-MeO-DMT or 5-methoxy-*[N]N*,*[N]N*-dimethyltryptamine 7431

Y. Alpha-methyltryptamine 7432

Z. Bufotenine 7433
Some trade and other names: 3-(b-Dimethylaminoethyl)-5-hydroxyindole; 3-(2-dimethylaminoethyl)-5-indolol; *[N]N*, *[N]N*-dimethylserotonin; 5-hydroxy-*[N]N*, *[N]N*-dimethyltryptamine; mappine;

AA. Diethyltryptamine 7434
Some trade and other names: *[N]N*, *[N]N*-Diethyltryptamine; DET;

BB. Dimethyltryptamine 7435
Some trade or other names: DMT;

CC. 5-methoxy-*[N]N*, *[N]N*-diisopropyltryptamine (other name: 5**-**MeO-DIPT) 7439

DD. Ibogaine 7260
Some trade and other names: 7-Ethyl-6,6β,7,8,9,10,12,13-octahydro-2-methoxy-6, 9-methano-5*[H]H*-pyrido [1',2':1,2] azepino [5,4-b] indole; Tabernanthe iboga;

EE. Lysergic acid diethylamide 7315

FF. Marihuana 7360
Some trade or other names: marijuana;

GG. Mescaline 7381

HH. Parahexyl 7374
Some trade or other names: 3-Hexyl-1-hydroxy-7,8,9,10-tetrahydro-6,6,9-trimethyl-6*[H]H*-dibenzo[b,d]pyran; Synhexyl;

II. Peyote 7415
Meaning all parts of the plant presently classified botanically as Lophophora williamsii Lemaire, whether growing or not; the seeds thereof; any extract from any part of such plant; and every compound, manufacture, salt, derivative, mixture**,** or preparation of such plant, its seeds**,** or extracts;

JJ. *[N]N*-ethyl-3-piperidyl benzilate 7482

KK. *[N]N*-methyl-3-piperidyl benzilate 7484

LL. Psilocybin 7437

MM. Psilocyn 7438

NN. Tetrahydrocannabinols naturally contained in a plant of the genus Cannabis (cannabis 7370 plant), as well as synthetic equivalents of the substances contained in the cannabis plant or in the resinous extractives of such plant, and/or synthetic substances, derivatives and their isomers, or both, with similar chemical structure and pharmacological activity to those substances contained in the plant, such as the following:

(I) 1 cis or trans tetrahydrocannabinol and their optical isomers;

(II) 6 cis or trans tetrahydrocannabinol and their optical isomers;

(III) 3,4 cis or trans tetrahydrocannabinol and its optical isomers; and

(IV) Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions are covered*[.]***;**

OO. Ethylamine analog of phencyclidine 7455
Some trade or other names: *[N]N*-ethyl-1-phenylcyclohexylamine, (1-phenylcyclohexyl) ethylamine, *[N]N*-(1-phenylcyclohexyl)-ethylamine, cyclohexamine, PCE;

PP. Pyrrolidine analog of phencyclidine 7458
Some trade or other names: 1-(1-phenylcyclohexyl)-pyrrolidine PCPy, PHP;

QQ. Thiophene analog of phencyclidine 7470
Some trade or other names: 1-(1-(2-thienyl)-cyclohexyl)-piperidine, 2-thienyl analog of phencyclidine, TPCP, TCP;

RR. 1-(1-(2-thienyl)cyclohexyl) pyrrolidine 7473
Some other names: TCPy*[.]*;

SS. Salvia divinorum;

TT. Salvinorin A;

UU. Synthetic cannabinoids: Unless specifically exempted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, or which contains their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(I) Any compound structurally derived from 3-(1-naphthoyl)indole or 1*[H]H*-indol-3-yl-(1-naphthyl)methane by substitution at the nitrogen atom of the indole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*[N]N*-methyl-2-piperidinyl)methyl**,** or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent, whether or not substituted in the naphthyl ring to any extent. Including, but not limited to:

(a) AM2201, or 1-(5-fluoropentyl)-3-(1-naphthoyl)indole 7201
(b) JWH-007, or 1-pentyl-2-methyl-3-(1-naphthoyl)indole
(c) JWH-015, or 1-propyl-2-methyl-3-(1-naphthoyl)indole
(d) JWH-018, or 1-pentyl-3-(1-naphthoyl)indole 7118
(e) JWH-019, or 1-hexyl-3-(1-naphthoyl)indole 7019
(f) JWH-073, or 1-butyl-3-(1-naphthoyl)indole 7173
(g) JWH-081, or 1-pentyl-3-(4-methoxy-1-naphthoyl)indole 7081
(h) JWH-098, or 1-pentyl-2-methyl-3-(4-methoxy-1-naphthoyl)indole
(i) JWH-122, or 1-pentyl-3-(4-methyl-1-naphthoyl)indole 7122
(j) JWH-164, or 1-pentyl-3-(7-methoxy-1-naphthoyl)indole
(k) JWH-200, or 1-(2-(4-(morpholinyl)ethyl))-3-(1-naphthoyl)indole 7200
(l) JWH-210, or 1-pentyl-3-(4-ethyl-1-naphthoyl)indole
(m) JWH-398, or 1-pentyl-3-(4-chloro-1-naphthoyl)indole 7398

(II) Any compound structurally derived from 3-(1-naphthoyl)pyrrole by substitution at the nitrogen atom of the pyrrole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*[N]N*-methyl-2-piperidinyl)methyl**,** or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the pyrrole ring to any extent, whether or not substituted in the naphthyl ring to any extent;

(III) Any compound structurally derived from 1-(1-naphthylmethyl)indene by substitution at the 3-position of the indene ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*[N]N*-methyl-2-piperidinyl)methyl**,** or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent;

(IV) Any compound structurally derived from 3-phenylacetylindole by substitution at the nitrogen atom of the indole ring with alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*[N]N*-methyl-2-piperidinyl)methyl**,** or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Including, but not limited to:

(a) JWH-201, or 1-pentyl-3-(4-methoxyphenylacetyl)indole
(b) JWH-203, or 1-pentyl-3-(2-chlorophenylacetyl)indole 7203
(c) JWH-250, or 1-pentyl-3-(2-methoxyphenylacetyl)indole 6250
(d) JWH-251, or 1-pentyl-3-(2-methylphenylacetyl)indole
(e) RCS-8, or 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole 7008

(V) Any compound structurally derived from 2-(3-hydroxycyclohexyl)phenol by substitution at the 5-position of the phenolic ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*[N]N*-methyl-2-piperidinyl)methyl**,** or 2-(4-morpholinyl)ethyl group, whether or not substituted in the cyclohexyl ring to any extent. Including, but not limited to:

(a) CP 47,497 & homologues, or 2-[(1R,3S)-3- hydroxycyclohexyl]-5-(2-methyloctan-2-yl)phenol), where side chain n=5, and homologues where side chain n-4,6, or 7; 7297, 7298

(VI) Any compound containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*[N]N*-methyl-2-piperidinyl)methyl**,** or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Including, but not limited to:

(a) AM-694, or 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole 7694
(b) RCS-4, or 1-pentyl-3-(4-methoxybenzoyl)indole (SR-19 and RCS-4) 7104

(VII) CP 50,556-1, or [(6S,6aR,9R,10aR)-9-hydroxy-6-methyl-3-[(2R)-5-phenylpentan-2-yl]oxy-5,6,6a,7,8,9,10,10a-octahydrophenanthridin-1-yl] acetate;

(VIII) HU-210, or (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol;

(IX) HU-211, or Dexanabinol,(6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol; **and**

(X) Dimethylheptylpyran, or DMHP**.**

*[4.]***5.** Depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture**,** or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Gamma-hydroxybutyric acid and other names GHB; gamma-hydroxybutyrate; 4-hydroxybutyrate; 4-hydroxybutonic acid; sodium oxybate; sodium oxybutryrate; 2010
B. Mecloqualone 2572
C. Methaqualone 2565

*[5.]***6.** Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture**,** or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers:

A. Aminorex 1585
Some trade or other names: aminoxaphen; 2-amino-5-phenyl-2-oxazoline; 4,5-dihydro-5-phenyl-2-oxazolamine;

B. *[N]N*-benzylpiperazine 7493
*[(s]*Some other names: BZP, 1-benzylpiperzaine*[)]*;

C. Cathinone 1235
*[(]*Some trade or other names: 2-amino-1-phenyl-1-propanone, alphaaminopropiophenone, 2-aminopropiophenone and norephedrone*[)]*;

D. Fenethylline 1503
E. 3-Fluoromethcathinone 1233
F. 4-Fluoromethcathinone 1238
G. Mephedrone, or 4-methylmethcathinone 1248
H. Methcathinone 1237
Some trade or other names: 2-(methylamino)-propiophenone; alpha-(methylamino) propiophenone; 2-(methylamino)-1-phenylpropan-1-one; alpha-*[N]N*-methylaminopropiophenone; monomethylpropion; ephedrone; *[N]N*-methylcathinone; methylcathinine; AL-464; AL-422; AL-463; and URI 432;

I. 4-methoxymethcathinone

J. cis-4-methylaminorex (cis-4,5-dihydro-4-methyl-5-phenyl-2-oxazolamine) 1590
K. Methylenedioxypyrovalerone, MDPV, or (1-(1,3-Benzodioxol-5-yl)-2-(1-pyrrolidinyl)-1-pentanone 7535
L. Methylone, or 3,4-Methylenedioxymethcathinone 7540
M. 4-Methyl-alpha-pyrrolidinobutiophenone, or MPBP
N. *[N]N*-ethylamphetamine 1475
O. *[N]N*,*[N]N*-dimethylamphetamine 1480
*[(s]*Some other names: *[N]N*,*[N]N*-alpha-trimethylbenzeneethanamine; N,N-alpha-trimethylphenethylamine*[)]*;
P. Quinolin-8-yl 1-pentyl-1*H*-indole-3-carboxylate (PB-22; QUPIC) 7222
Q. Quinolin-8-yl 1-(5-fluoropentyl)-1*H*-indole-3-carboxylate (5-fluoro-PB-22; 5F-PB-22) 7225
R. *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamide (AB-FUBINACA) 7012
S. *N*-(1-amino-3, 3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1*H*-indazole-3-carboxamide (ADB-PINACA) 7035

*[6.]*7. A temporary listing of substances subject to emergency scheduling under federal law shall include any material, compound, mixture, or preparation which contains any quantity of the following substances:

A. (1-pentyl-1*H*-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl) methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: UR-144, 1-pentyl-3-(2,2,3,3-tetramethylcyclopropoyl)indole) 7144
B. [1-(5-fluoro-pentyl)-1*H*-indol-3-yl](2,2,3,3-tetramethylcyclopropyl) methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5- fluoro-UR-144, 5-F-UR-144, XLR11, 1-(5-fluoro-pentyl)-3-(2,2,3,3-tetramethylcyclopropoyl)indole) 7011
C. *N*-(1-adamantyl)-1-pentyl-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomer (Other names: APINACA, AKB48) 7048
D. 2-(4-iodo-2,5-dimethoxyphenyl)-*N*-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25I-NBOMe; 2C-I-NBOMe; 25I; Cimbi-5) 7538
E. 2-(4-chloro-2,5-dimethoxyphenyl)-*N*-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25C-NBOMe; 2C-C-NBOMe; 25C; Cimbi-82) 7537
F. 2-(4-bromo-2,5- dimethoxyphenyl)-*N*-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25B-NBOMe; 2C-B-NBOMe; 25B; Cimbi-36) 7536
G. 4-methyl-*N*-ethylcathinone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-MEC; 2-(ethylamino)-1-(4-methylphenyl)propan-1-one) 1249
H. 4-methyl-*alpha*-pyrrolidinopropiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-MePPP; MePPP; 4-methyl-α-pyrrolidinopropiophenone; 1-(4-methylphenyl)-2-(pyrrolidin-1-yl)-propan-1-one) 7498
I. *alpha*-pyrrolidinopentiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: α-PVP; α-pyrrolidinovalerophenone; 1-phenyl-2-(pyrrolidin-1-yl)pentan-1-one) 7545
J. Butylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: bk-MBDB; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one) 7541
K. Pentedrone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: α-methylaminovalerophenone; 2-(methylamino)-1-phenylpentan-1-one) 1246
L. Pentylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: bk-MBDP; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one) 7542
M. Naphyrone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: naphthylpyrovalerone; 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one) 1258
N. *alpha*-pyrrolidinobutiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: α-PBP; 1-phenyl-2-(pyrrolidin-1-yl)butan-1-one) 7546
O. *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: AB-CHMINACA) 7031
P. *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: AB-PINACA) 7023
Q. [1-(5-fluoropentyl)-1*H*-indazol-3-yl](naphthalen-1-yl)methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: THJ-2201) 7024
[R. N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: butyryl fentanyl) 9822]
*[S.]*R. *[N]N*-[1-[2-hydroxy-2-(thiophen-2-yl) ethyl]piperidin-4-yl]-*[N]N*-phenylpropionamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: beta-hydroxythiofentanyl) 9836
*[T.]*S. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: acetyl fentanyl) 9821
*[U.]*T. *[N]N*-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MAB-CHMINACA; ADB-CHMINACA) 7032
[V. 3, 4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methylbenzamide (Other names: U-47700) 9547]
*[W.]*U. N-(1-phenethylpiperidin-4-yl)-N-phenylfuran-2-carboxamide (Other names: furanyl fentanyl) 9834
V. methyl 2-(1-(5-fluoropentyl)-1*H*-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F–ADB; 5F–MDMB–PINACA) (7034)
W. methyl 2-(1-(5-fluoropentyl)-1*H*-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F–AMB) (7033)

X. *N*-(adamantan-1-yl)-1-(5-fluoropentyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F–APINACA, 5F–AKB48) **(7049)**

Y. *N*-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: ADB–FUBINACA) **(7010)**

Z. methyl 2-(1-(cyclohexylmethyl)-1*H*-indole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MDMB–CHMICA, MMB–CHMINACA) **(7042)**

AA. methyl 2-(1-(4-fluorobenzyl)- 1*H*-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MDMB–FUBINACA) **(7020)**

BB. *N*-(4-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: 4-fluoroisobutyryl fentanyl, *para*-fluoroisobutyryl fentanyl) **(9824)**

CC. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacrylamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: acryl fentanyl, acryloylfentanyl) **(9811)**

DD. *N*-(2-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl)propionamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: *ortho*-fluorofentanyl, 2-fluorofentanyl) **(9816)**

EE. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenyltetrahydrofuran-2-carboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: tetrahydrofuranyl fentanyl) **(9843)**

FF. 2-methoxy-*N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: methoxyacetyl fentanyl) **(9825)**

GG. methyl 2-(1-(4-fluorobenzyl)-1 *H*-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: FUB–AMB, MMB–FUBINACA, AMB–FUBINACA) **(7021)**

HH. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylcyclopropanecarboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: cyclopropyl fentanyl) **(9845)**

II. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylpentanamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: valeryl fentanyl) **(9804)**

JJ. *N*-(4-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl) butyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-fluorobutyryl fentanyl) **(9823)**

KK. *N*-(4-methoxyphenyl)-*N*-(1-phenethylpiperidin-4-yl)butyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-methoxybutyryl fentanyl) **(9837)**

LL. *N*-(4-chlorophenyl)-*N*-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-chloroisobutyryl fentanyl) **(9826)**

MM. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylisobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: isobutyryl fentanyl) **(9827)**

NN. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylcyclopentanecarboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: cyclopentyl fentanyl) **(9847)**

OO. *N*-(2-fluorophenyl)-2-methoxy-*N*-(1-phenethylpiperidin-4-yl)acetamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: ocfentanil) **(9832)**

PP. Fentanyl-related substances, their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers. **9850**

(I) Fentanyl-related substance means any substance not otherwise listed under another Administration Controlled Substance Code Number, and for which no exemption or approval is in effect under section 505 of the Federal Food, Drug, and Cosmetic Act 21 U.S.C. 355, that is structurally related to fentanyl by one or more of the following modifications:

(a) Replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;

(b) Substitution in or on the phenethyl group with alkyl, alkenyl, alkoxyl, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(c) Substitution in or on the piperidine ring with alkyl, alkenyl, alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(d) Replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; and/or

(e) Replacement of the *N*-propionyl group by another acyl group;

QQ. Naphthalen-1-yl 1-(5-fluoropentyl)-1*H*-indole-3-carboxylate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: NM2201; CBL2201) **(7221)**

RR. *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-AB-PINACA) **(7025)**

SS. 1-(4-cyanobutyl)-*N*-(2-phenylpropan-2-yl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-CN-CUMYL-BUTINACA; 4-cyano-CUMYL-BUTINACA; 4-CN-CUMYLBINACA; CUMYL-4CN-BINACA; SGT-78) **(7089)**

TT. methyl 2-(1-(cyclohexylmethyl)-1*H*-indole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MMB-CHMICA, AMB-CHMICA) **(7044)**

UU. 1-(5-fluoropentyl)-*N*-(2-phenylpropan-2-yl)-1*H*-pyrrolo[2,3-b]pyridine-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-CUMYL-P7AICA) **(7085)**

VV. *N*-Ethylpentylone, its optical, positional, and geometric isomers, salts, and salts of isomers

(Other names: ephylone, 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one) (7543)

*[7.]***8.** Khat, to include all parts of the plant presently classified botanically as catha edulis, whether growing or not; the seeds thereof; any extract from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seed**,** or extracts. 7032

(B) Schedule II shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name**,** or brand name designated, listed in this section. Each drug or substance has been assigned the Controlled Substances Code Number set forth opposite it.

1. Substances, vegetable origin, or chemical synthesis. Unless specifically excepted or unless listed in another schedule, Schedule II shall include any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

A. Opium and opiate; and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, thebaine-derived butorphanol, dextrorphan, nalbuphine, nalmefene, naloxegol, naloxone, and naltrexone and their respective salts, but including the following:

(I) Raw opium 9600
(II) Opium extracts 9610
(III) Opium fluid 9620
(IV) Powdered opium 9639
(V) Granulated opium 9640
(VI) Tincture of opium 9630
(VII) Codeine 9050
(VIII) Dihydroetorphine 9334
(IX) Ethylmorphine 9190
(X) Etorphine hydrochloride 9059
(XI) Hydrocodone 9193
(XII) Hydromorphone 9150
(XIII) Metopon 9260
(XIV) Morphine 9300
(XV) Oripavine 9330
(XVI) Oxycodone 9143
(XVII) Oxymorphone 9652
(XVIII) Thebaine 9333

B. Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subparagraph (1)(B)1.A. of this rule shall be included in Schedule II, except that these substances shall not include the isoquinoline alkaloids of opium;

C. Opium poppy and poppy straw*[;]* 9650

D. Coca leaves (9040) and any salt, compound, derivative, or preparation of coca leaves (including cocaine (9041) and ecgonine (9180) and their salts, isomers, derivatives, and salts of isomers and derivatives), and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include:

(I) Decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine; or

(II) Ioflupane*[.]***;**

E. Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid, or powder form which contains the phenanthrene alkaloids of the opium poppy) 9670

2. Opiates. Unless specifically excepted or unless in another schedule any of the following opiates, including its isomers, esters, ethers, salts**,** and salts of isomers, esters**,** and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation, dextrorphan**,** and levopropoxyphene excepted:

A. Alfentanil 9737
B. Alphaprodine 9010
C. Anileridine 9020
D. Bezitramide 9800
E. Bulk Dextropropoxyphene (Non-dosage Forms) 9273
F. Carfentanil 9743
G. Dihydrocodeine 9120
H. Diphenoxylate 9170
I. Fentanyl 9801
J. Isomethadone 9226
K. Levo-alphacetylmethadol 9220
Some other names: levo-alphaacetylmethadol, levomethadyl acetate, LAAM 9648
L. Levomethorphan 9210
M. Levorphanol 9220
N. Metazocine 9240
O. Methadone 9250
P. Methadone-Intermediate, 4-cyano-2-dimethylamino-4,4-diphenyl butane 9254
Q. Moramide-Intermediate, 2-methyl-3-morpholino-1, 1-diphenylpropane-carboxylic acid 9802
R. Pethidine (Meperidine) 9230
S. Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine 9232
T. Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate 9233
U. Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid 9234
V. Phenazocine 9715
W. Piminodine 9730
X. Racemethorphan 9732
Y. Racemorphan 9733
Z. Remifentanil 9739
AA. Sufentanil 9740
BB. Tapentadol 9780
CC. Thiafentanil 9729

3. Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

A. Amphetamine, its salts, optical isomers, and salts of its optical isomers 1100
B. Lisdexamfetamine, its salts, isomers, and salts of its isomers 1205
C. Methamphetamine, its salts, isomers, and salts of its isomers 1105
D. Phenmetrazine and its salts 1631
E. Methylphenidate 1724

4. Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Amobarbital 2125
B. Glutethimide 2550
C. Pentobarbital 2270
D. Phencyclidine 7471
E. Secobarbital 2315

5. Hallucinogenic substances:

A. Nabilone 7379
Another name for nabilone: (±)trans-3-(1, 1-dimethylheptyl)-6, 6a,7,8,10,10a-hexahydro-1-hydroxy-6, 6-dimethyl-9H-dibenzo(b,d) pyran-9-one.

B. Dronabinol [(-)-delta-9-*trans* tetrahydrocannabinol] in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration. (7365)

6. Immediate precursors. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances:

A. Immediate precursor to amphetamine and methamphetamine:

(I) Phenylacetone 8501
Some trade or other names: phenyl-2- propanone; P2P; benzyl methyl ketone; methyl benzyl ketone;

B. Immediate precursors to phencyclidine (PCP):
(I) 1-phenylcyclohexylamine 7460
(II) 1-piperidinocyclo-hexanecarbonitrile (PCC) 8603

C. Immediate precursor to fentanyl:
(I) 4-anilino-*[N]N*-phenethyl-4-piperidine (ANPP) 8333

7. Any material, compound, mixture, or preparation which contains any quantity of the following alkyl nitrites:

A. Amyl nitrite**;**

B. Butyl nitrite.

(E) Schedule V shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this subsection.

1. Narcotic drugs containing nonnarcotic active medicinal ingredients. Any compound, mixture, or preparation containing any of the following narcotic drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities as follows, which shall include one (1) or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

A. Not more than two hundred milligrams (200 mg) of codeine per one hundred milliliters (100 mL) or per one hundred grams (100 g);

B. Not more than one hundred milligrams (100 mg) of dihydrocodeine per one hundred milliliters (100 mL) or per one hundred grams (100 g);

C. Not more than one hundred milligrams (100 mg) of ethylmorphine per one hundred milliliters (100 mL) or per one hundred grams (100 g)*[.]***;**

D. Not more than two and five-tenths milligrams (2.5 mg) of diphenoxylate and not less than twenty-five micrograms (25 mcg) of atropine sulfate per dosage unit*[.]***;**

E. Not more than one hundred milligrams (100 mg) of opium per one hundred milliliters (100 mL) or per one hundred grams (100 g)*[.]***; and**

F. Not more than five-tenths milligram (0.5 mg) of difenoxin (DEA Drug Code No. 9168) and not less than twenty-five micrograms (25 mcg) of atropine sulfate per dosage unit.

2. Stimulants. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system including its salts, isomers, and salts of isomers:

A. Pyrovalerone 1485

3. Any compound, mixture, or preparation containing any detectable quantity of pseudoephedrine or its salts or optical isomers, or salts of optical isomers or any compound, mixture, or preparation containing any detectable quantity of ephedrine or its salts or optical isomers, or salts of optical isomers if the drug preparations are starch-based solid dose forms, if such preparations are sold over the counter without a prescription. The following drug preparations containing ephedrine and pseudoephedrine are not scheduled controlled substances:

A. Drug preparations in liquid form;

B. Drug preparations that require a prescription in order to be dispensed.

4. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts:

A. Ezogabine [N-[2-amino-4(4- fluorobenzylamino)-phenyl]-carbamic acid ethyl ester] 2779
B. Lacosamide [(R)-2-acetoamido-N-benzyl-3-methoxy-propionamide] 2746
C. Pregabalin [(S)-3-(aminomethyl)-5-methylhexanoic acid] 2782
D. Brivaracetam ((25)-2-[(4R)-2-oxo-4-propylpyrrolidin-1-yl]butanamide) (also referred to as BRV; UCB-34714; Briviact) 2710

5. Approved cannabidiol drugs.

A. A drug product in finished dosage formulation that has been approved by the U.S. Food and Drug Administration that contains cannabidiol (2-[1R-3-methyl-6R-(1-methylethenyl)-2-cyclohexen-1-yl]-5-pentyl-1,3-benzenediol) derived from cannabis and no more than one tenth percent (0.1%) (w/w) residual tetrahydro cannabinols 7367

AUTHORITY: sections 195.015 and 195.195, RSMo 2016. Material found in this rule previously filed as 19 CSR 30-1.010. Original rule filed April 14, 2000, effective Nov. 30, 2000. Amended: Filed Jan. 31, 2003, effective July 30, 2003. Amended: Filed Sept. 30, 2016, effective May 30, 2017. Emergency amendment filed Oct. 25, 2018, effective Nov. 4, 2018, expires May 2, 2019. Amended: Filed Oct. 25, 2018.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment, by contacting Michael Boeger with the Missouri Department of Health and Senior Services, Bureau of Narcotics and Dangerous Drugs, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 6—Privacy of Consumer Information

PROPOSED AMENDMENT

20 CSR 100-6.100 Privacy of Financial Information. The director is amending sections (1), (2), (3), (4), and (5) and deleting Appendix 1 which follows the rule in the *Code of State Regulations.*

PURPOSE: This amendment reflects changes to the federal Gramm-Leach-Bliley Act made by Congress through the enactment of the Fixing America's Surface Transportation Act (FAST) in 2015 (Pub. L. No. 114-94). These changes eliminated the GLBA requirement for financial institutions to provide annual privacy notices about treatment of nonpublic personal information under certain conditions. These GLBA changes eliminated duplicative and costly notification requirements for financial institutions, including insurance companies. Amending this rule aligns state law with federal law.

(1) Definitions. As used in this rule, unless the context requires otherwise:

(B) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice. For example:

1. *[Reasonably understandable.]* A licensee makes its notice reasonably understandable if it:

A. Presents the information in the notice in clear, concise sentences, paragraphs, and sections;

B. Uses short explanatory sentences or bullet lists whenever possible;

C. Uses definite, concrete, everyday words and active voice whenever possible;

D. Avoids multiple negatives;

E. Avoids legal and highly technical business terminology whenever possible; and

F. Avoids explanations that are imprecise and readily subject to different interpretations.

2. *[Designed to call attention.]* A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee*[:]*—

A. Uses a plain-language heading to call attention to the notice;

B. Uses a typeface and type size that are easy to read;

C. Provides wide margins and ample line spacing;

D. Uses boldface or italics for key words; and

E. In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

3. *[Notices on web sites.]* If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page**,** if necessary**,** to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either*[:]*—

A. Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

B. Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature**,** and relevance of the notice.

(F) "Consumer" means an individual who seeks to obtain, obtains**,** or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative. For example:

1. An individual who provides nonpublic personal information to a licensee in connection with obtaining**,** or seeking to obtain**,** financial, investment**,** or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship;

2. An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer;

3. An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution;

4. An individual is a licensee's consumer if:

A. The individual is:

(I) A beneficiary of a life insurance policy underwritten by the licensee;

(II) A claimant under an insurance policy or certificate issued by the licensee*[, other than a third-party claimant]*;

(III) An insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee;

(IV) A mortgagor of a mortgage covered under a mortgage insurance policy; and

B. The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under subsections (4)(A), (4)(B), and (4)(C) of this rule;

5. Provided that the licensee provides the initial, annual**,** and revised notices under subsections (2)(A), (2)(B), and (2)(E) of this rule to the plan sponsor, group**,** or blanket insurance policyholder**,** or group annuity contractholder, and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under subsections (4)(A), (4)(B), and (4)(C) of this rule, an individual is not the consumer of the licensee solely because he or she is:

A. A participant or a beneficiary of an employee benefit plan that the licensee administers**,** or sponsors**,** or for which the licensee acts as a trustee, insurer**,** or fiduciary;

B. Covered under a group or blanket insurance policy or group annuity contract issued by the licensee;

6. The individuals described in subparagraphs (1)(F)5.A. and (1)(F)5.B. are consumers of a licensee if the licensee does not meet all the conditions of paragraph (1)(F)5. In no event shall the individuals, solely by virtue of the status described in subparagraphs (1)(F)5.A. and (1)(F)5.B. of this subsection, be deemed to be customers for purposes of this rule;

7. An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee;

8. An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

(H) "Control" means:

1. Ownership, control**,** or power to vote twenty-five percent (25%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one (1) or more other persons;

2. Control in any manner over the election of a majority of the directors, trustees**,** or general partners (or individuals exercising similar functions) of the company; or

3. The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the *[commissioner]* **director** determines.

(J) "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family**,** or household purposes. *[Examples.]*

1. A consumer has a continuing relationship with a licensee if*[:]*—

A. The consumer is a current policyholder of an insurance product issued by or through the licensee; or

B. The consumer obtains financial, investment**,** or economic advisory services relating to an insurance product or service from the licensee for a fee.

2. A consumer does not have a continuing relationship with a licensee if*[:]*—

A. The consumer applies for insurance but does not purchase the insurance;

B. The licensee sells the consumer airline travel insurance in an isolated transaction;

C. The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

D. The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

E. The consumer is a beneficiary or a claimant under a policy and has submitted a claim under a policy choosing a lump sum settlement option;

F. The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than annual privacy notices, material required by law or rule, communication at the direction of a state or federal authority, or promotional materials;

G. The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

H. For the purposes of this rule, the individual's last known address according to the licensee's records is deemed invalid. An

address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(M) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state*[. Insurance service includes]*, **including** a licensee's evaluation, brokerage**,** or distribution of information that the licensee collects in connection with a request or an application from a consumer for *[a]* **an** insurance product or service.

(N) "Licensee" means all licensed insurers, producers**,** and other persons licensed [*or required to be licensed, or authorized or required to be authorized, or registered or required to be registered]*, **authorized, or registered, or required to be licensed, authorized, or registered** by the director pursuant to the laws of this state.

1. A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in sections (1), (2), (3), and (4) of this rule if the licensee is an employee, agent**,** or other representative of another licensee ("the principal") and:

A. The principal otherwise complies with, and provides *[the]* notices *[required by,]* **pursuant to** the provisions of this rule; and

B. The licensee does not disclose any nonpublic personal information to any other person other than the principal or its affiliates in a manner permitted by this rule, other than as permitted by subparagraph (4)(B)1.E.

2. Nonadmitted insurers.

A. Subject to subparagraph (1)(N)1.B., "licensee" *[shall]* also include**s** a nonadmitted insurer that accepts business placed through a licensed surplus lines broker in this state, but only in regard to the surplus lines placements placed pursuant to Chapter 384, RSMo.

B. A surplus lines broker or surplus lines insurer *[shall be]* **is** deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in sections (1), (2), (3), and (4) of this rule provided*[:]***—**

(I) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under subsection (4)(A) of this rule, except as permitted by subsection*[s]* (4)(B) or (4)(C) of this rule; and

(II) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in sixteen (16)-point type:

PRIVACY NOTICE

NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW.

(O) "Nonaffiliated third party."

*[1. "Nonaffiliated third party" means a]***A**ny person except*[:]*

*[A. A]***a** licensee's affiliate*[;]* or

*[B. A]***a** person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person).

*[2. Nonaffiliated third party includes a]***A**ny company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) or insurance company investment activities of the type described in section 4(k)(4)(I) of the federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I)) **is a nonaffiliated third party**.

(Q) "Nonpublic personal financial information."

1. "Nonpublic personal financial information" means*[:]*

A.] Personally identifiable financial information; and

*[B. A]***a**ny list, description**,** or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personal*[ly]* identifiable financial information that is not publicly available.

2. Nonpublic personal financial information does not include*[:]***—**

A. Publicly available information, except as included on a list described in subparagraph (1)(Q)1.B.; or

B. Any list, description**,** or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

[(I) Examples of lists.]

*[(a)]***(I)** Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personal*[ly]* identifiable financial information that is not publicly available, such as account numbers.

*[(b)]***(II)** Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personal*[ly]* identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

(R) "Personal*[ly]* identifiable financial information."

[1. "Personally identifiable financial information"] means any information:

*[A.]***1.**A consumer provides to a licensee to obtain an insurance product or service from the licensee;

*[B.]***2.** About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

*[C.]***3.** The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

[2. Examples.]

*[A.]***4.** *[Information included.]* Personal*[ly]* identifiable financial information includes*[:]***—**

*[(I)]***A.** Information a consumer provides to a licensee on an application to obtain an insurance product or service;

*[(II)]***B.** Account balance information and payment history;

*[(III)]***C.** The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

*[(IV)]***D.** Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

*[(V)]***E.** Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

*[(VI)]***F.** Any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and

*[(VII)]***G.** Information from a consumer report.

*[B.]***5.** *[Information not included.]* Personally identifiable financial information does not include*[:]***—**

*[(I)]***A.** A list of names and addresses of customers of an entity that is not a financial institution; and

*[(II)]***B.** Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names**,** or addresses.

(S) "Publicly available information*[.]*"

[1. "Publicly available information"] means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from*[:]*

*A. F]***f**ederal, state**,** or local government records;

*[B. W]***w**idely distributed media; or

*[C. D]***d**isclosures to the general public *[that are required to be]* made *[by]* **pursuant to** federal, state**,** or local law.

*[2.]***1.** *[Reasonable basis.]* A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine*[:]***—**

A. That the information is of the type that is available to the general public; and

B. Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

*[3.]***2.** Examples.

A. *[Government records.]* Publicly available information in government records includes information in government real estate records and security interest filings.

B. *[Widely distributed media.]* Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper**,** or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

C. Reasonable basis.

(I) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(II) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

(T) "Third-party claimant" has the same meaning as in subsection 20 CSR 100-1.010(1)(H).

(2) Privacy and Opt Out Notices For Financial Information.

(A) Initial Privacy Notice to Consumers *[Required]*.

1. *[Initial notice requirement.]* A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to*[:]***—**

A. *[Customer.]* An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in paragraph (2)(A)5.; and

B. *[Consumer.]* A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by subsections (4)(B) and (4)(C).

2. *[When initial notice to a consumer is not required.]* A licensee is not required to provide an initial notice to a consumer under subparagraph (2)(A)1.B. if:

A. The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by subsections (4)(B) and (4)(C), and the licensee does not have a customer relationship with the consumer; or

B. A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

3. When the licensee establishes a customer relationship.

A. *[General rule.]* A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

B. *[Examples of establishing customer relationship.]* A licensee establishes a customer relationship when the consumer*[:]***—**

(I) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

(II) Agrees to obtain financial, economic**,** or investment advisory services relating to insurance products or services for a fee from the licensee.

4. *[Existing customers.]* When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family**,** or household purposes, the licensee satisfies the initial notice requirements of paragraph (2)(A)1. as follows:

A. The licensee may provide a revised policy notice, under subsection (2)(E), that covers the customer's new insurance product or service; or

B. If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under paragraph (2)(A)1.

5. Exceptions to allow subsequent delivery of notice.

A. A licensee may provide the initial notice *[required by]* **pursuant to** paragraph (2)(A)1. of this section within a reasonable time after the licensee establishes a customer relationship if*[:]***—**

(I) Establishing the customer relationship is not at the customer's election; or

(II) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

B. Examples of exceptions.

(I) *[Not at customer's election.]* Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(II) [*Substantial delay of customer's transaction.*] Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(III) *[No substantial delay of customer's transaction.]* Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

6. *[Delivery.]* When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to subsection (2)(F). If the licensee uses a short-form initial notice for non-customers according to paragraph (2)(C)4., the licensee may deliver its privacy notice according to subparagraph (2)(C)4.C.

(B) Annual Privacy Notice to Customers *[Required]*.

1. *[General rule.]* A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve (12) consecutive months during which that relationship exists. A licensee may define the twelve (12)-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

2. *[Example.]* A licensee provides a notice annually if it defines the twelve (12)-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year 1, the licensee *[shall]* **will** provide an annual notice to that customer by December 31 of year 2.

3. A licensee that provides nonpublic personal information to nonaffiliated third parties only in accordance with subsections (4)(A), (4)(B), or (4)(C) and has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the

most recent disclosure sent to consumers in accordance with this subsection or subsection (2)(A) is not required to provide an annual disclosure under this section until such time as the licensee fails to comply with any criteria described in this paragraph.

*[3.]***4.** *[Termination of customer relationship.]* A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

A. Examples.

(I) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

(II) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired**,** or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than to provide annual privacy notices, material *[required by]* **provided pursuant to** law or rule, or promotional materials.

(III) For the purposes of this rule, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable**,** and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(IV) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

4. *[Delivery.]* When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to subsection (2)(F).

(C) Information to Be Included in Privacy Notices.

1. *[General rule.]* The initial, annual**,** and revised privacy notices that a licensee provides under subsections (2)(A), (2)(B) and (2)(E) shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

A. The categories of nonpublic personal financial information that the licensee collects;

B. The categories of nonpublic personal financial information that the licensee discloses;

C. The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under subsections (4)(B) and (4)(C);

D. The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under subsections (4)(B) and (4)(C);

E. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under subsection (4)(A) (and no other exception in subsections (4)(B) and (4)(C) applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

F. An explanation of the consumer's right under paragraph (3)(A)1. to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

G. Any disclosures that the licensee makes under section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

H. The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

I. Any disclosure that the licensee makes under paragraph (2)(C)2.

2. *[Description of parties subject to exceptions.]* If a licensee discloses nonpublic personal financial information as authorized under subsections (4)(B) and (4)(C), the licensee is not required to list those exceptions in the initial or annual privacy notices *[required by]* **provided pursuant to** subsections (2)(A) and (2)(B). When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

3. Examples.

A. *[Categories of nonpublic personal financial information that the licensee collects.]* A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(I) Information from the consumer;

(II) Information about the consumer's transactions with the licensee or its affiliates;

(III) Information about the consumer's transactions with nonaffiliated third parties; and

(IV) Information from a consumer reporting agency.

B. Categories of nonpublic personal financial information a licensee discloses.

(I) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in subparagraph (2)(C)3.A., as applicable, and provides a few examples to illustrate the types of information in each category. These might include*[:]*—

(a) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address and social security number;

(b) Transaction information, such as information about balances, payment history and parties to the transaction; and

(c) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(II) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(a) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

C. Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(I) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(II) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(III) A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

D. Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in subsection (4)(A) to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of subparagraph (2)(C)1.E. if it:

(I) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of subparagraph (2)(C)1.B., as applicable; and

(II) States whether the third party is:

(a) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(b) A financial institution with whom the licensee has a joint marketing agreement.

E. *[Simplified notices.]* If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under subsections (4)(B) and (4)(C), the licensee may simply state that fact, in addition to the information it *[shall]* provide**s** under subparagraphs (2)(C)1.A., (2)(C)1.H., (2)(C)1.I., and paragraph (2)(C)2.

F. *[Confidentiality and security.]* A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it *[does both of the following:*

[(I) **D**escribe**s** in general terms who is authorized to have access to the information; and

*[(II) S]***s**tates whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

4. Short-form initial notice with opt out notice for non-customers.

A. A licensee may satisfy the initial notice requirements in subparagraph (2)(A)1.B. and paragraph (2)(D)4. for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice *[as required in]* **pursuant to** subsection (2)(D).

B. A short-form initial notice shall*[:]***—**

(I) Be clear and conspicuous;

(II) State that the licensee's privacy notice is available upon request; and

(III) Explain a reasonable means by which the consumer may obtain that notice.

C. The licensee shall deliver its short-form initial notice according to subsection (2)(F). The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to subsection (2)(F).

D. *[Examples of obtaining privacy notice.]* The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee*[:]***—**

(I) Provides a toll-free telephone number that the consumer may call to request the notice; or

(II) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

5. *[Future disclosures.]* The licensee's notice may include*[:]***—**

A. Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

B. Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

6. *[Sample clauses.]* Sample clauses illustrating some of the notice content *[required by]* **described in** this section are *[included herein as Appendix A of this rule]* **are available on the department's website at www.insurance.mo.gov**.

(D) Form of Opt Out Notice to Consumers and Opt Out Methods.

1. Form of opt out notice. If a licensee is required to provide an opt out notice under paragraph (3)(A)1., it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section*[. The notice shall state:]***, and which states:**

A. That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

B. That the consumer has the right to opt out of that disclosure; and

C. A reasonable means by which the consumer may exercise the opt out right.

2. Examples.

A. *[Adequate opt out notice.]* A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee*[:]***—**

(I) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in subparagraphs (2)(C)1.B. and (2)(C)1.C., and states that the consumer can opt out of the disclosure of that information; and

(II) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

B. *[Reasonable opt out means.]* A licensee provides a reasonable means to exercise an opt out right if it*[:]***—**

(I) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(II) Includes a reply form together with the opt out notice;

(III) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

(IV) Provides a toll-free telephone number that consumers may call to opt out.

C. *[Unreasonable opt out means.]* A licensee does not provide a reasonable means of opting out if*[:]***—**

(I) The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

(II) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice**,** but did not include with the subsequent notice.

D. *[Specific opt out means.]* A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

3. *[Same form as initial notice permitted.]* A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with subsection (2)(A).

4. *[Initial notice required when opt out notice delivered subsequent to initial notice.]* If a licensee provides the opt out notice later than required for the initial notice in accordance with subsection (2)(A), the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

5. Joint relationships.

A. If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice*[. The licensee's opt out notice shall explain]***, which explains** how the licensee will treat an opt out direction by a

joint consumer (as explained in subparagraph (2)(D)5.E.).

B. Any of the joint consumers may exercise the right to opt out. The licensee may either*[:]*—

(I) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(II) Permit each joint consumer to opt out separately.

C. If a licensee permits each joint consumer to opt out separately, the licensee shall permit one (1) of the joint consumers to opt out on behalf of all of the joint consumers.

D. A licensee may not require all joint consumers to opt out before it implements any opt out direction.

E. Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt-out notice which opt out policy the licensee will follow:

(I) Send a single opt out notice to John's address, but *[the licensee shall]* accept an opt out direction from either John or Mary.

(II) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(III) Permit John and Mary to make different opt out directions. If the licensee does so*[:]*—

(a) It shall permit John and Mary to opt out for each other;

(b) If both opt out, the licensee shall permit both of them to notify it in a single response (such as on a form or through a telephone call); and

(c) If John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John**,** and not about John and Mary jointly.

6. *[Time to comply with opt out.]* A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

7. *[Continuing right to opt out.]* A consumer may exercise the right to opt out at any time.

8. Duration of consumer's opt out direction.

A. A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees*[,]* electronically.

B. When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

9. *[Delivery.]* When a licensee *[is required to]* deliver**s** an opt out notice *[by]* **pursuant to** this section, the licensee shall deliver it according to subsection (2)(F).

(E) Revised Privacy Notices.

1. *[General rule.]* Except as otherwise authorized in this rule, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under subsection (2)(A), unless*[:]*—

A. The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

B. The licensee has provided to the consumer a new opt out notice;

C. The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

D. The consumer does not opt out.

2. Examples.

A. Except as otherwise permitted by subsections (4)(A), (4)(B), and (4)(C), a licensee shall provide a revised notice before it:

(I) Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

(II) Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

(III) Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

B. A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

3. *[Delivery.]* When a licensee *[is required to]* deliver**s** a revised privacy notice *[by]* **pursuant to** this section, the licensee shall deliver it according to subsection (2)(F).

(F) Delivery.

1. *[How to provide notices.]* A licensee shall provide any notices that this rule requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

2. *[Examples of reasonable expectation of actual notice.]* A licensee may reasonably expect that a consumer will receive actual notice if the licensee*[:]*—

A. Hand-delivers a printed copy of the notice to the consumer;

B. Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or**,** other written communication;

C. For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

D. For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

3. *[Examples of unreasonable expectation of actual notice.]* A licensee may not, *[however,]* reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it*[:*

*A. O]***o**nly posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

*[B. S]***s**ends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

4. *[Annual notices only.]* A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if*[:]*—

A. The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

B. The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

5. Oral description of notice insufficient. A licensee may not provide any notice *[required by]* **pursuant to** this rule solely by orally explaining the notice, either in person or over the telephone.

6. Retention or accessibility of notices for customers.

A. For customers only, a licensee shall provide the initial notice *[required by]* **outlined in** subparagraph (2)(A)1.A., the annual notice *[required by]* **outlined in** paragraph (2)(B)1., and the revised notice *[required by]* **outlined in** subsection (2)(E) so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

B. *[Examples of retention or accessibility.]* A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee*[:]*—

(I) Hand-delivers a printed copy of the notice to the customer;

(II) Mails a printed copy of the notice to the last known address of the customer; or

(III) Makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

7. *[Joint notice with other financial institutions.]* A licensee may provide a joint notice from the licensee and one **(1)** or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

8. *[Joint relationships.]* If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual**,** and revised notice requirements of paragraphs (2)(A)1., (2)(B)1. and (2)(E)1., respectively, by providing one notice to those consumers jointly.

(3) Limits on Disclosures of Financial Information.

(A) Limits on Disclosure of Nonpublic Personal Financial Information to Nonaffiliated Third Parties.

1. Conditions for disclosure. Except as otherwise authorized in this rule, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless*[:]*—

A. The licensee has provided to the consumer an initial notice *[as required under]* **pursuant to** subsection (2)(A);

B. The licensee has provided to the consumer an opt out notice *[as required in]* **pursuant to** subsection (2)(D);

C. The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

D. The consumer does not opt out.

2. *[Opt out definition.]* Opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by subsections (4)(A), (4)(B), and (4)(C).

A. *[Examples of reasonable opportunity to opt out.]* A licensee provides a consumer with a reasonable opportunity to opt out if*[:]*—

(I) *[By mail.]* The licensee mails the notices *[required]* **described** in paragraph (3)(A)1. to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number**,** or any other reasonable means within thirty (30) days from the date the licensee mailed the notices.

(II) *[By electronic means.]* A customer opens an on-line account with a licensee and agrees to receive the notices *[required]* **described** in paragraph (3)(A)1. electronically, and the licensee allows the customer to opt out by any reasonable means within thirty (30) days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(III) *[Isolated transaction with consumer.]* For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices *[required]* **described** in paragraph (3)(A)1. at the time of the transaction**,** and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

3. Application of opt out to all consumers and all nonpublic personal financial information.

A. A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

B. Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

4. *[Partial opt out.]* A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

(B) Limits on Redisclosure and Reuse of Nonpublic Personal Financial Information.

1. Information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in subsection (4)(B) or (4)(C) of this rule, the licensee's disclosure and use of that information is limited as follows:

A. The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

B. The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

C. The licensee may disclose and use the information pursuant to an exception in subsection (4)(B) or (4)(C) of this rule, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(I) Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

2. Information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in subsection (4)(B) or (4)(C) of this rule, the licensee may disclose the information only*[:]*—

A. To the affiliates of the financial institution from which the licensee received the information;

B. To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

C. To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information. Example: If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in subsection (4)(B) or (4)(C)*[:]***,**

*[(I) T]***t**he licensee may use that list for its own purposes; and

*[(II) T]***t**he licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in subsections (4)(B) or (4)(C), such as to the licensee's attorneys or accountants.

3. *[Information a licensee discloses under an exception.]* If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in subsections (4)(B) or (4)(C) of this rule, the third party may disclose and use that information only as follows:

A. The third party may disclose the information to the licensee's affiliates;

B. The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information;

and

C. The third party may disclose and use the information pursuant to an exception in subsection (4)(B) or (4)(C) in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

4. *[Information a licensee discloses outside of an exception.]* If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in subsection (4)(B) or (4)(C) of this rule, the third party may disclose the information only:

A. To the licensee's affiliates;

B. To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

C. To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

(C) Limits on Sharing Account Number Information for Marketing Purposes.

1. *[General prohibition on disclosure of account numbers.]* A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing**,** or other marketing through electronic mail to the consumer.

2. *[Exceptions.]* Paragraph (3)(C)1. does not apply if a licensee discloses a policy number or similar form of access number or access code:

A. To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

B. To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

C. To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

3. Examples.

A. *[Policy number.]* A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

B. *[Policy or transaction account.]* For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

(4) Exceptions to Limits on Disclosures of Financial Information.

(A) Exception to Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Service Providers and Joint Marketing.

1. General rule.

A. The opt out requirements in subsections (2)(D) and (3)(A) do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(I) Provides the initial notice in accordance with subsection (2)(A); and

(II) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in subsection (4)(B) or (4)(C) in the ordinary course of business to carry out those purposes.

B. *[Example.]* If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of part (4)(A)1.A.(II) if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in subsection (4)(B) or (4)(C) in the ordinary course of business to carry out that joint marketing.

2. *[Service may include joint marketing.]* The services a nonaffiliated third party performs for a licensee under paragraph (4)(A)1. of this section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one (1) or more financial institutions.

3. *[Definition of "joint agreement."]* For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one (1) or more financial institutions jointly offer, endorse or**,** sponsor a financial product or service.

(B) Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Processing and Servicing Transactions.

1. *[Exceptions for processing transactions at consumer's request.]* The requirements for initial notice in subparagraph (2)(A)1.B., the opt out in subsections (2)(D) and (3)(A), and service providers and joint marketing in subsection (4)(A) do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer**,** or enforce a transaction that a consumer requests or authorizes, or in connection with*[:]*—

A. Servicing or processing an insurance product or service that a consumer requests or authorizes;

B. Maintaining or servicing the consumer's account with a licensee*[,]* or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

C. A proposed or actual securitization, secondary market sale (including sales of servicing rights)**,** or similar transaction related to a transaction of the consumer;

D. Reinsurance or stop loss or excess loss insurance; or

E. Soliciting insurance quotes on behalf of a consumer by an agent or a broker.

2. "Necessary to effect, administer or enforce a transaction" means that the disclosure is*[:]*—

A. Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

B. Required, or is a usual, appropriate**,** or acceptable method:

(I) To carry out the transaction or the product or service business of which the transaction is a part, and record, service**,** or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(II) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(III) To provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(IV) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(V) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects or as otherwise required or specifically permitted by federal or state law; or

(VI) In connection with*[:]*—

(a) The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited**,** or otherwise paid using a debit, credit**,** or other payment

card, check or account number, or by other payment means;

(b) The transfer of receivables, accounts**,** or interests therein; or

(c) The audit of debit, credit**,** or other payment information.

(C) Other Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information.

1. *[Exceptions to opt out requirements.]* The requirements for initial notice in subparagraph (2)(A)1.B., the opt out in subsections (2)(D) and (3)(A), and service providers and joint marketing in subsection (4)(A) do not apply when a licensee discloses nonpublic personal financial information*[:]***—**

A. With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

B. To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product**,** or transaction;

C. To protect against or prevent actual or potential fraud or unauthorized transactions;

D. For required institutional risk control or for resolving consumer disputes or inquiries;

E. To persons holding a legal or beneficial interest relating to the consumer;

F. To persons acting in a fiduciary or representative capacity on behalf of the consumer;

G. To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants**,** and auditors;

H. To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 *et seq.*), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a state insurance authority, and the Federal Trade Commission), self-regulatory organizations or for an investigation on a matter related to public safety;

I. To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 *et seq.*);

J. From a consumer report reported by a consumer reporting agency;

K. In connection with a proposed or actual sale, merger, transfer**,** or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

L. To comply with federal, state**,** or local laws, rules**,** and other applicable legal requirements;

M. To comply with a properly authorized civil, criminal**,** or regulatory investigation, or subpoena or summons by federal, state**,** or local authorities;

N. To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance**,** or other purposes as authorized by law; or

O. For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan, or a workers' compensation plan.

2. *[Example of revocation of consent.]* A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under paragraph (2)(D)7.

(5) Additional Provisions.

(A) *[Protection of Fair Credit Reporting Act.]* Nothing in this rule *[shall]* **may** be construed to modify, limit**,** or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 *et seq.*), and no inference *[shall]* **may** be drawn on the basis of the provisions of this rule regarding whether information is transaction or experience information under section 603 of that Act.

(B) *[Nondiscrimination.]* A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this rule. Nothing in this subsection *[shall]* **may** be construed to prohibit the use of usual, appropriate, or acceptable methods of insurance underwriting.

(C) *[Severability.]* If any section or portion of a section of this rule or its applicability to any person or circumstance is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected.

(D) Effective Date.

[1. Effective date. This rule becomes effective thirty (30) days after publication in the Code of State Regulations.] After the effective date of this rule, no licensee may disclose nonpublic personal financial information to nonaffiliated third parties without first complying with the provisions of section (3) of this rule, including subparagraph (3)(A)1.A. *[For consumers who became customers before July 1, 2001, the initial notices required by section (2)(A) must be given by June 30, 2002.]*

[2. Two (2)-year grandfathering of service agreements. Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of part (4)(A)1.A.(II) of this rule, even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before July 1, 2000.

APPENDIX A—SAMPLE CLAUSES

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A-1—Categories of information a licensee collects (all institutions)
A licensee may use this clause, as applicable, to meet the requirement of subparagraph (2)(C)1.A. to describe the categories of nonpublic personal information the licensee collects.
Sample Clause A-1:
We collect nonpublic personal information about you from the following sources:
• Information we receive from you on applications or other forms;
• Information about your transactions with us, our affiliates or others; and
• Information we receive from a consumer reporting agency.

A-2—Categories of information a licensee discloses (institutions that disclose outside of the exceptions)
A licensee may use one of these clauses, as applicable, to meet the requirement of subparagraph (2)(C)1.B. to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses

nonpublic personal information other than as permitted by the exceptions in subsections (4)(A), (4)(B), and (4)(C).
Sample Clause A-2, Alternative 1:
We may disclose the following kinds of nonpublic personal information about you:
• Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, ad-dress, social security number, assets, income, and beneficiaries"];
• Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premiums, and payment history"]; and
• Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your credit-worthiness and credit history"].
Sample Clause A-2, Alternative 2:
We may disclose all of the information that we collect, as described [describe location in the notice, such as "above" or "below"].

A-3—Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)
A licensee may use this clause, as applicable, to meet the requirements of subparagraphs (2)(C)1.B., (2)(C)1.C., and (2)(C)1.D. to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in subsections (4)(B) and (4)(C).
Sample Clause A-3:
We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4—Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)
A licensee may use this clause, as applicable, to meet the requirement of subparagraph (2)(C)1.C. to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in subsections (4)(A), (4)(B), and (4)(C), as well as when permitted by the exceptions in subsections (4)(B) and (4)(C).
Sample Clause A-4:
We may disclose nonpublic personal information about you to the following types of third parties:
• Financial service providers, such as [provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents"];
• Non-financial companies, such as [provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"]; and
• Others, such as [provide illustrative examples, such as "non-profit organizations"].
We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5—Service provider/joint marketing exception
A licensee may use one of these clauses, as applicable, to meet the requirements of subparagraph (2)(C)1.E. related to the exception for service providers and joint marketers in subsection (4)(A). If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.
Sample Clause A-5, Alternative 1:
We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:
• Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];
• Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premium, and payment history"]; and
• Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your credit-worthiness and credit history"].
Sample Clause A-5, Alternative 2:
We may disclose all of the information we collect, as described [describe location in the notice, such as "above" or "below"] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6—Explanation of opt out right (institutions that disclose outside of the exceptions)
A licensee may use this clause, as applicable, to meet the requirement of subparagraph (2)(C)1.F. to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in subsections (4)(A), (4)(B), and (4)(C).
Sample Clause A-6:
If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [describe a reasonable means of opting out, such as "call the following toll-free number: (insert number)"].

A-7—Confidentiality and security (all institutions)
A licensee may use this clause, as applicable, to meet the requirement of subparagraph (2)(C)1.H. to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.
Sample Clause A-7:
We restrict access to nonpublic personal information about you to [provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"]. We maintain physical, electronic, and procedural safeguards that comply with federal rules to guard your nonpublic personal information.]

*AUTHORITY: sections 362.422[, RSMo Supp. 2007] and [section] 374.045, RSMo [2000] **2016**. Emergency rule filed June 21, 2001, effective July 1, 2001, expired Dec. 28, 2001. Original rule filed Aug. 31, 2001, effective March 30, 2002. Amended: Filed Nov. 1, 2007, effective July 30, 2008. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Amy V. Hoyt, PO Box 690, Jefferson City, MO. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 9—Filing Requirements

PROPOSED AMENDMENT

20 CSR 100-9.100 Requirements for the Filing of Papers, Documents, or Reports with the Insurance Market Regulation Division. The director is amending sections (1), (2), (3), and the existing section (4), and adding a new subsection.

PURPOSE: The purpose of this amendment is to consolidate all rules related to requirements for filings made with the Insurance Market Regulation Division, and to amend the filing fee amounts to comply with section 374.230, SS SB 982, 99th Gen. Assemb. (2018).

(1) Scope. This rule is applicable to any company filing papers, documents, or reports, which are *[required to be]* filed under Missouri law, with the Insurance Market Regulation Division, as permitted by law.

(2) Definitions. As used in 20 CSR 100-9.100 the following terms mean:

(G) Document—any form, rate, **report,** or rule that is legally required to be delivered either to the division, or to the department or director through the division, and any other form, rate, **report,** or rule intended to be delivered either to the division, or to the department**,** or director through the division. Documents do not include any form, rate, **report,** or rule that is legally required to be delivered either to the market conduct section or to the department or director through the market conduct section;

(H) Filing Submission—one (1) or more related documents, which have been delivered through SERFF under a single SERFF tracking number *[by a company]*, that has not yet been treated as filed, received, or deficient;

(N) Report—any report **or certification** that is legally required to be delivered either to the division, or to the department**,** or director through the division, and any other report intended to be delivered either to the division, or to the department**,** or director through the division. A report does not include: any statistical data submitted to the division pursuant to a data call under section 374.190, RSMo, or any report that is legally required to be delivered either to the market conduct section or to the department or director through the market conduct section;

(3) Filing Requirements.

(A) All documents *[must be]* **are** submitted.

(D) Any document that supersedes another document within a filing submission will be treated as a new filing submission. *[The new filing submission must meet all requirements within this rule except]* **All provisions in this rule apply except** that no additional fee will be charged **for any document that supersedes another document within a filing submission**.

(4) Filing Requirements for Life Insurance. Life insurance forms must be submitted separately from health insurance forms, pursuant to section 376.010. However, this restriction does not apply where the combination of coverage is inherent to the plan design of group coverage.

*[(4)]***(5)** Filing Fees.

(A) *[Any filing submission, e]***E**xcept as provided below or otherwise provided by statute, **a filing submission** must include a filing fee of **one hundred** fifty dollars (**$1**50) per submission per company. **If any company which is a member of a group of related companies makes a filing on behalf of any or all of the companies in that group, the filing is considered a separate filing for each of the companies on behalf of which the filing was made, and each of those companies will pay a filing fee.**

1. With respect to a **filing submission for a company not formed under Chapter 380 or a discount medical plan formed under Chapter 376, the filing fee is one hundred fifty dollars ($150) per form submitted to the division.**

2. With respect to a farm mutual, formed under Chapter 380, RSMo, no filing fee *[is required for any such filing submission]* **will be charged**.

*[2.]***3.** With respect to any extended farm mutual, formed under Chapter 380, RSMo, *[any such filing submission must include a]* **the** filing fee *[of]* **is** ten dollars ($10) per form **submitted to the division**.

*[3.]***4.** With respect to any discount medical plan, formed under Chapter 376, RSMo, *[any such filing submission must include a]* **the** filing fee *[of]* **is** twenty-five dollars ($25) per form **submitted to the division**.

(B) *[Any filing submission, paper, or report]* **All filing fees for any filing submission** must be *[paid for]* **remitted** through the SERFF Electronic Funds Transfer (EFT) system.

*AUTHORITY: sections **354.085,** 354.120, **354.485,** 354.723, **374.045, 374.056,** 375.013, **376.405,** 376.675, 376.1025, 376.1095, **376.1399,** 379.351, [and] 380.561, [RSMo 2000, and sections 354.085, 354.485, 374.045, 374.056, 376.405, 376.777, 376.1399,] 381.042, and 383.035, RSMo [Supp. 2013] **2016**. Original rule filed July 15, 2015, effective Jan. 30, 2016. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Amy V. Hoyt, PO Box 690, Jefferson City, MO. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.005 Materials *[Incorporated by Reference]* ***to be Utilized by the Director***. The director is amending sections (1) and

(2), deleting section (3), amending the rule title, amending the purpose statement, and removing the publisher's note.

PURPOSE: This amendment maintains clear guidance on publications used by the department while removing references to specific editions of the publications in the rule, thereby ensuring that the most recent publication will be in effect.

PURPOSE: The purpose[s] of this rule [are to prescribe forms and procedures to be followed in proceedings before the Department of Insurance, Financial Institutions and Professional Registration and] ***is*** *to effectuate or aid in the interpretation of any law of this state pertaining to the business of insurance, by providing specific information regarding certain publications [incorporated by reference]* ***utilized by the director in the furtherance of his or her statutory duties and referenced*** *in rules in this division.*

(1) The director *[adopts and incorporates by reference in rules of this division]* **may utilize** the following *[rules, regulations, standards, and guidelines]* **publications** of the National Association of Insurance Commissioners (NAIC) *[without publishing the materials in full]* **in the furtherance of his or her statutory duties**:

(A) *Accounting Practices and Procedures Manual [(March 2011)]*, also referred to as the Accounting Practices and Procedures Manual for Fire and Casualty Insurance Companies and as the Accounting Practices and Procedures Manual for Life and Accident and Health Insurance Companies;

(B) *Annual Statement Instructions [(August 2010)]*;

(C) *Purposes and Procedures Manual of the NAIC [Securities Valuation]* ***Investment Analysis*** *Office [(July 1, 2010)]*, also referred to as the Valuation of Securities; *[and]*

(D) *Financial Condition Examiner['']s Handbook [(2010)]*, also referred to as the Examiner's Handbook**; and**

(E) ***Financial Analysis Handbook***.

(2) The above referenced *[rules, regulations, standards, or guidelines do not include any later amendments or additions]* **publications are updated annually or biannually by the NAIC. The director will maintain a list of the above referenced publications on the department's website, with the editions currently in use clearly specified. References in rules of this department to the above referenced publications refer to the editions listed on the department's website, unless otherwise specified.**

[(3) The publisher's name and address is the National Association of Insurance Commissioners, Central Office, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662.]

AUTHORITY: section 374.045, RSMo [Supp. 2010] ***2016****. Original rule filed July 15, 2009, effective Feb. 28, 2010. Amended: Filed Feb. 14, 2011, effective Aug. 30, 2011. Amended: Filed Oct. 30, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED RESCISSION

20 CSR 200-1.010 Financial Condition of Insurance Companies. This rule enumerated conditions which may have indicated that an insurer was in a financial condition which would require further scrutiny in order to protect its policyholders, claimants, creditors, shareholders, and the public.

PURPOSE: This rule is being rescinded because it was superseded by the enactment of section 375.539, RSMo in 2010.

AUTHORITY: sections 374.040, 374.045 and 374.190, RSMo 2000 and Chapter 375, RSMo 2000 and Supp. 2001. This rule was previously filed as 4 CSR 190-11.005. Original rule filed Aug. 1, 1990, effective Dec. 31, 1990. Amended: Filed July 2, 1991, effective Dec. 9, 1991. Amended: Filed April 29, 1992, effective Dec. 3, 1992. Amended: Filed July 12, 2002, effective Jan. 30, 2003. Rescinded: Filed Oct. 30, 2018.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.020 Accounting Standards and Principles. The director is amending sections (1)–(3) and amending the purpose statement.

PURPOSE: This amendment updates the references within the rule to reflect changes in Missouri statute and regulation.

PURPOSE: This rule effectuates or aids in the interpretation of sections [375.560 and] ***354.470, 375.537, 375.539,*** *375.881,* ***375.1160, 375.1165, and 375.1175,*** *RSMo, and in the administration of sections 354.080 and 354.355, RSMo.*

(1) Each insurance company shall make and file statements of its assets, liabilities, capital and surplus, income and expenses, including all schedules and exhibits used in connection with such statements, which statements the director may use to determine *[whether the capital stock or guarantee fund of an insurance company is impaired under section 375.560.1(1), RSMo,*

whether an insurance company is insolvent under section 375.560.1(2) or 375.881.1(1), RSMo, whether an insurance company is in a financial condition that its the further transaction of business would be hazardous under section 375.881.1(3) or 375.1165(1), RSMo and whether an insurance company fails to comply with the requirements for admission under section 375.881.1(2), RSMo] **any of the following** according to the applicable accounting guidance, standards, and principles approved by the National Association of Insurance Commissioners (NAIC), published in the *Accounting Practices and Procedures Manual, Annual Statement Instructions, Valuation of Securities [and]*, *Examiner's Handbook*, **and *Financial Analysis Handbook*,** except where the applicable provisions of Chapters 374–385, RSMo or other specific rules expressly provide otherwise*[.]*:

(A) Whether an insurance company is impaired under section 375.537, RSMo;

(B) Whether any standards are implicated under section 375.539.2, RSMo;

(C) Whether an insurance company is insolvent under section 375.881(1) or 375.1175.1(2), RSMo;

(D) Whether an insurance company fails to comply with the requirements for admission under section 375.881(2), RSMo;

(E) Whether an insurance company is in such a financial condition that its further transaction of business in this state would be hazardous to policyholders and creditors in this state and to the public under section 375.881(3), RSMo;

(F) Whether an insurance company's condition renders the continuance of its business hazardous to the public or to its insureds under section 375.1160.2(1)(a), RSMo;

(G) Whether an insurance company is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public under section 375.1165(1), RSMo; and

(H) Whether an insurance company is found to be in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors or the public under section 375.1175.1(3), RSMo.

(2) Each health services corporation shall make and file statements of its assets, liabilities, capital and surplus, income and expenses, including all schedules and exhibits used in connection with such statements, which statements the director may use to determine *[whether a health services corporation is maintaining the reserves required by section 354.080, RSMo and whether a health services corporation is in a condition that its further transaction of business will be hazardous under section 354.355(3), RSMo]* **any of the following** according to the applicable accounting **guidance,** standards *[or]*, **and** principles approved by the NAIC, *[or both, as]* published in the *Accounting Practices and Procedures Manual, Annual Statement Instructions, Valuation of Securities [and]*, *Examiner's Handbook*, **and *Financial Analysis Handbook*,** except where the applicable provisions of *[sections 354.010–354.380]* **Chapters 354 and 374-385**, RSMo or other specific rules expressly provide otherwise*[.]*:

(A) Whether a health services corporation is maintaining reserves in accordance with section 354.080, RSMo;

(B) Whether a health services corporation is in such condition that its further transaction of business will be hazardous to its policyholders or to its creditors or to the public under section 354.355(3), RSMo;

(C) Whether a health services corporation is impaired under section 375.537, RSMo;

(D) Whether any standards are implicated under section 375.539.2, RSMo;

(E) Whether a health services corporation's condition renders the continuance of its business hazardous to the public or to its insureds under section 375.1160.2(1)(a), RSMo;

(F) Whether a health services corporation is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public under section 375.1165(1), RSMo;

(G) Whether a health services corporation is insolvent under section 375.1175.1(2), RSMo; and

(H) Whether a health services corporation is found to be in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public under section 375.1175.1(3), RSMo.

(3) Each health maintenance organization shall make and file statements of its assets, liabilities, capital and surplus, income and expenses, including all schedules and exhibits used in connection with such statements, which statements the director may use to determine *[whether a health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees under section 354.470.1(4), RSMo, whether the continued operation of a health maintenance organization would be hazardous to its enrollees under section 354.470.1(8), RSMo, whether a health maintenance organization is insolvent under section 375.1175(2), RSMo, and whether a health maintenance organization is in a financial condition that its further transaction of business would be hazardous under section 375.1165(1), RSMo,]* **any of the following** according to the applicable accounting guidance, standards, and principles approved by the *[National Association of Insurance Commissioners (]*NAIC*[)]*, published in the *Accounting Practices and Procedures Manual, Annual Statement Instructions, Valuation of Securities [and]*, *Examiner's Handbook*, **and *Financial Analysis Handbook*,** except where the applicable provisions of Chapters 354 **and 374-385**, RSMo or other specific rules expressly provide otherwise*[.]*:

(A) Whether a health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees under section 354.470.1(4), RSMo;

(B) Whether the continued operation of a health maintenance organization would be hazardous to its enrollees under section 354.470.1(8), RSMo;

(C) Whether a health maintenance organization is impaired under section 375.537, RSMo;

(D) Whether any standards are implicated under section 375.539.2, RSMo;

(E) Whether a health maintenance organization's condition renders the continuance of its business hazardous to the public or to its insureds under section 375.1160.2(1)(a), RSMo;

(F) Whether a health maintenance organization is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public under section 375.1165(1), RSMo;

(G) Whether a health maintenance organization is insolvent under section 375.1175.1(2), RSMo; and

(H) Whether a health maintenance organization is found to be in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public under section 375.1175.1(3), RSMo.

*AUTHORITY: sections 354.120, 354.485, and 374.045, RSMo [2000] **2016**. This rule was previously filed as 4 CSR 190-11.230. Original rule filed Feb. 3, 1989, effective May 1, 1989. Amended: Filed Aug. 25, 1989, effective Jan. 1, 1990. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed Dec. 4, 2001, effective June 30, 2002. Amended: Filed Oct. 30, 2018.*

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

PRIVATE COST: This proposed amendment will not cost private enti-

ties more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.025 Valuation of Invested Assets. The director is amending section (2) and amending the purpose statement.

PURPOSE: This amendment updates a statutory reference and simplifies a reference to publications of the National Association of Insurance Commissioners.

PURPOSE: This rule effectuates or aids in the interpretation of sections [376.300–376.320] ***376.291–376.307*** *and 379.080, RSMo.*

(2) Other Invested Assets. Invested assets, other than securities, must be valued in accordance with the procedures *[promulgated by the NAIC's Financial Condition (EX4) Subcommittee as]* published in *[its]* **the NAIC** *Accounting Practices and Procedures Manual, Annual Statement Instructions [and]* **and** *Examiner's Handbook*.

AUTHORITY: section 374.045, RSMo [2000] ***2016****. Original rule filed July 2, 1991, effective Dec. 9, 1991. Amended: Filed Aug. 29, 2003, effective Feb. 29, 2004. Amended: Filed Oct. 30, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED RESCISSION

20 CSR 200-1.039 Supplemental Filing Requirements for Material Transactions. This rule aided in the interpretation of sections 354.105, 354.190, 354.435, 354.465, 354.717, 354.720, 374.190, 375.041, 375.400, 376.350, 377.100, 377.380, 378.626, 379.105, 381.241, 383.030 and 384.021, RSMo, and required domestic insurance companies to disclose material transactions as addenda to the annual and quarterly financial statement filings in order to protect policyholders, claimants, creditors, shareholders, and the public.

PURPOSE: This rule is being rescinded because it exceeds the department's statutory authority with respect to multiple statutes cited in its purpose statement, and because it is not currently enforced.

AUTHORITY: sections 354.120, 354.485, 354.723, 374.045, 375.013 and 381.231, RSMo 1994. Original rule filed Aug. 1, 1995, effective March 30, 1996. Rescinded: Filed Oct. 30, 2018.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.040 Financial Standards for Health Maintenance Organizations. The director is amending sections (1)–(5) and adding a new section (6).

PURPOSE: This amendment modernizes the rule and removes outdated and unnecessary provisions.

(1) A health maintenance organization (HMO) must maintain a capital account *[as required by]* **pursuant to** section 354.410.6*[.]*, RSMo. The capital account is the equivalent of net worth and shall be equal to the assets of the HMO less its liabilities, which is also the equivalent of "net of any accrued liabilities" as used in section 354.410.6*[.]*, RSMo. Assets and liabilities will be admitted and determined under the provisions of this rule.

(2) Assets of an HMO will be admitted and included in determining the financial condition of the HMO only if included within one (1) or more of the following list of admissible assets:

(A) Investable funds under section 354.450, RSMo are as follows:

1. Any asset or investment described in and limited by sections *[375.1070—375.1075, RSMo, and 376.300, 376.305 and 376.307]* **376.291-376.307**, RSMo; and

2. Any asset or investment described in and limited by section 354.415.1(1), RSMo. *[Under section 354.415.2, RSMo, the HMO must file notice and adequate supporting information with the director for any asset or investment in excess of five hundred thousand dollars ($500,000). If the director*

does not disapprove the notice within sixty (60) days of the date of filing, the notice shall be deemed approved] **The requirements of section 354.415.2, RSMo apply as detailed in the statute**; and

(B) Other assets as follows:

1. Reinsurance recoverables pursuant to section 375.246, RSMo;

2. Data processing system pursuant to section 375.325, RSMo;

3. Premium receivable from any agency of this state, of any political subdivision of this state or of the United States;

4. Accrued interest receivable, if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for HMOs such interest is probably collectible;

5. Inventory of medical, pharmaceutical and optical supplies, furniture, equipment and fixtures, but only if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for HMOs such supplies, furniture, equipment and fixtures are used by the HMO in connection with the direct provision of health care services;

6. Funds paid by the HMO into escrow for the purpose of purchasing or building offices or medical facilities but only if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for HMOs such offices or facilities are for use by the HMO in connection with the direct provision of health care services;

7. Goodwill and other intangible assets. Any goodwill or intangible asset must be amortized on a straight-line basis over a period of five (5) years or less. Any goodwill or intangible asset accrued after September 1, 1989 will be admissible only with the prior consent of the director;

8. Amounts receivable from HMOs, health service corporations, insurance companies, self-insurance plans**,** and third-party tortfeasors on account of coordination of benefits or subrogation, limited to the less of the actual amounts receivable or the amounts received during the prior year;

9. Any other asset expressly approved in writing by the director.

(3) No asset shall be admissible except as stated in section (2) **and in accordance with the statements of statutory accounting principles**. *[The following is a non-exclusive list of nonadmitted assets and no item listed may be admitted under section 376.307, RSMo:]*

[(A) Premiums receivable net of bad debt allowance when the receivable is greater than ninety (90) days past due, except as allowed in paragraph (2)(B)3.;

(B) Prepaid expenses, except as allowed in paragraph (2)(B)6.;

(C) Security deposits;

(D) Automobiles;

(E) Office furniture and equipment in excess of fifty percent (50%) of its depreciated value;

(F) Computer software;

(G) Letters of credit, except to secure reinsurance credit as outlined in section 375.246, RSMo, pledges to purchase stock or other guarantees by outside organizations;

(H) Capital leases; and

(I) Any asset expressly disapproved in writing by the director.]

(4) Liabilities shall be determined *[by the instructions to the National Association of Insurance Commissioners (NAIC) blank annual statement form for HMOs except the following need not be reflected as liabilities:]* **in accordance with the statements of statutory accounting principles.**

[(A) Capital leases; and

(B) Any debt subordinated and approved under 20 CSR 200-1.070.]

(5) In determining whether an HMO is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees under sections 354.410.1(3) and 354.470.1(4), RSMo and whether the continued operation of the HMO would be hazardous either to the enrollees or to the people of this state under section 354.480, RSMo, the director *[requires compliance with the following minimum standards:]* **will consider compliance with the standards of sections 354.410, 375.539, and 375.1250-375.1275, RSMo.**

[(A) A new HMO forming initially, and for its first full calendar year of operation, must have net worth of at least ten percent (10%) of the yearly average of the three (3)-year annual premium projected in its applications for a certificate of authority, or three hundred thousand dollars ($300,000) if an individual practice association, or one hundred fifty thousand dollars ($150,000) if a medical group/staff, whichever is greater. After an HMO has been in business from January 1 through December 31 of a year, that is, one (1) full calendar year, it shall be treated as an existing HMO;

(B) An existing HMO must maintain a net worth of at least two percent (2%) of annual premium as shown in the HMO's most recently filed annual statement, three hundred thousand dollars ($300,000) for an individual practice association, or one hundred fifty thousand dollars ($150,000) for a medical group/staff model, whichever is greater. The two percent (2%) of annual premium previously mentioned shall be phased in as follows:

1. Two-thirds of one percent (2/3 of 1%) of annual premium as of December 31, 1989;

2. One and one-third percent (1 1/3%) of annual premium as of December 31, 1990; and

3. Two percent (2%) of annual premium as of December 3, 1991 and after that date; and]

*[(C)]***(6)** On any policy of insolvency insurance, the named insured must include the director of the *[Missouri Department of Insurance]* **department** and his/her successor(s) in office.

*AUTHORITY: section 354.485, RSMo [2000] **2016**. This rule was previously filed as 4 CSR 190-11.125. Original rule filed April 19, 1989, effective Sept. 1, 1989. Amended: Filed Sept. 15, 1992, effective June 7, 1993. Amended: Filed Nov. 23, 1998, effective July 30, 1999. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.050 Financial Standards for Prepaid Dental Plans.

The director is amending sections (1)–(4) and deleting the editor's note.

PURPOSE: This amendment modernizes the rule and removes outdated and unnecessary provisions.

[Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.]

(1) Assets of a prepaid dental plan will be admitted and included in determining the financial condition of the prepaid dental plan only if included within one (1) or more of the following list of admissible assets:

(A) Investable funds invested as follows *[shall be deemed admissible assets]*:

1. Any asset or investment described in and limited by sections *[376.300, 376.305 and 376.307]* **376.291–376.307**, RSMo; and

2. Any asset or investment representing the purchase, lease, construction, renovation, operation or maintenance of facilities from which dental benefits under the plan will be performed or property as may reasonably be *[required]* **needed** for the principal office of the prepaid dental plan or for other purposes as may be necessary in the transaction of the business of the plan; and

(B) Other assets *[shall be determined admissible assets,]* as follows:

1. Reinsurance recoverables;

2. Data processing system;

3. Premium receivable from any agency of this state, of any political subdivision of this state or of the United States;

4. Accrued interest receivable, if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for prepaid dental plans such interest is probably collectable;

5. Inventory of dental supplies, but only if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for prepaid dental plans such supplies are used by the prepaid dental plan in connection with the direct provision of dental services;

6. Funds paid by the prepaid dental plan into escrow for the purpose of purchasing or building offices or facilities from which dental benefits under the plan will be performed, but only if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for prepaid dental plans such offices or facilities are for use by the prepaid dental plan in connection with the direct provision of health care services;

7. Goodwill and other intangible assets. Any goodwill or intangible asset must be amortized on a straight-line basis over a period of five (5) years or less. Any goodwill or intangible asset accrued after April 1, 1990 will be admissible only with the prior consent of the director;

8. Amounts receivable on account of coordination of benefits or subrogation, limited to the actual amounts receivable or the amounts received during the prior year, whichever is less;

9. Any other asset expressly approved in writing by the director.

(2) No asset shall be admissible except as stated in section (1) **and in accordance with the statements of statutory accounting principles**. *[The following list is a nonexclusive list of nonadmitted assets and no item listed may be admitted in determining the financial condition of the prepaid dental plan:]*

[(A) Premiums receivable net of bad debt allowance when the receivable is greater than ninety (90) days past due, except as allowed in paragraph (1)(B)3.;

(B) Prepaid expenses, except as allowed in paragraph (1)(B)6.;

(C) Security deposits;

(D) Automobiles;

(E) Office furniture and equipment;

(F) Computer software;

(G) Letters of credit, except to secure reinsurance credit as outlined in section 375.246, RSMo, pledges to purchase stock or other guarantees by outside organizations;

(H) Capital leases; and

(I) Any asset expressly disapproved in writing by the director.]

(3) Liabilities shall be determined *[by the instructions to the National Association of Insurance Commissioners (NAIC) blank annual statement form for health maintenance organizations or any blank annual statement forms designed specifically for prepaid dental plans except the following need not be reflected as liabilities:]* **in accordance with the statements.**

[(A) Capital leases; and

(B) Any debt subordinated and approved pursuant to 20 CSR 200-1.070.]

(4) *[In lieu of the examination by the director or any of his/her duly appointed agents, the director may accept a full report of an examination or audit of an independent certified public accountant. The report shall be based on the standards set out in this rule.]* **The director will consider compliance with the standards of section 375.539, RSMo when evaluating a prepaid dental plan under section 354.722, RSMo.**

*AUTHORITY: section 354.723, RSMo [2000] **2016**. This rule was previously filed as 4 CSR 190-11.280. Original rule filed Dec. 12, 1989, effective April 1, 1990. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.070 Subordinated Indebtedness. The director is amending sections (1)–(7) and amending the purpose statement.

PURPOSE: This amendment modernizes the rule and removes outdated and unnecessary language.

*PURPOSE: This rule specifies information [which must] **to** be submitted to the director for prior approval of subordinated indebtedness agreements, the form [which] **of** consideration for these agreements [must take] and the accounting procedures to be followed. This rule implements sections 354.355, 354.480, 375.535, [375.540, 375.560 and 380.271] **375.539, and 381.075**, RSMo.*

(1) Application. This rule applies to all health service corporations, health maintenance organizations (HMOs), insurance companies**,** and reciprocal interinsurance exchanges organized under the laws of this state and is applicable to any debts other than those shown as a legal liability of the company. Notwithstanding any other provision to the contrary, no company or other entity which has the power to assess its members may issue any subordinated indebtedness unless it is a mutual company organized under *[sections 379.205—379.310]* **Chapter 379**, RSMo.

(2) Definition, Subordinated Indebtedness (Surplus Notes). Subordinated indebtedness, for the purposes of this rule includes any contingent obligation for the repayment of a sum of money upon a written agreement that the loan or advance with interest shall be repaid only out of surplus profits of the company *[in excess of the minimum surplus as required by Missouri law and as shall be]***, as defined at 20 CSR 200-11.150(2), or as** deemed necessary by the director of insurance to secure the interests of the policyholders and creditors of this company.

(3) Approval by the Director.

(A) The following shall be submitted to the director *[of insurance]* for **prior** approval:

1. Duplicate copies of the entire **subordinated** indebtedness agreement; and

2. Certified copy of the resolution of the board of directors *[of proper company body]* or committee which is empowered to authorize these agreements. The resolution shall stipulate the maximum amount of subordinated indebtedness authorized and the purpose for which it is incurred. It also shall limit the application of the proceeds to the specific purpose for which the **subordinated** indebtedness is incurred.

(B) After submission of the documents and approval, the director may authorize the execution of the **subordinated** indebtedness agreement. All agreements shall be executed and the consideration received immediately after the approval **unless otherwise stated in the approval order**.

(C) Any amendment to or cancellation of an approved subordinated indebtedness agreement is to be submitted to the director for prior approval in accordance with subsection (3)(A) of this rule.

(4) Consideration. The consideration tendered to the company in exchange for the agreement shall be *[lawful money or other consideration as may be]* **in the form of cash or other admitted assets having readily determinable values and liquidity** acceptable to and approved by the director.

(5) Reporting and Accounting of **Subordinated** Indebtedness.

(A) The director shall be notified immediately in writing upon the execution of any **subordinated** indebtedness agreement as to the amount and to whom payable.

[(B) Any existing subordinated indebtedness incurred prior to March 29, 1976, also shall be reported immediately in writing to the director.]

*[(C)]***(B)** All outstanding subordinated indebtedness and interest accruing shall be reported at face value in the annual statement on page 3 and in other financial statements of the company as a special surplus account. **Accrued interest that has not been approved for payment should be accounted for by debiting unassigned funds and crediting the special surplus account.**

(6) Approval of Repayment by Director. Repayment of principal or payment of interest may be made only with the approval of the director when s/he is satisfied that the financial condition of the company warrants this action. **Repayment of surplus note interest should first reverse any unapproved accrued interest accounting by debiting the special surplus account and crediting unassigned funds. The interest payment should then be recorded by debiting interest expense and crediting cash. Repayment of principal should follow the guidance set forth in the National Association of Insurance Commissioners' *Accounting Practices and Procedures Manual*.**

(7) Other Loans. Nothing in this section *[shall]* **is to** be construed to mean that a company *[may not]* **cannot** otherwise borrow money, but the amount so borrowed with accrued interest shall be carried by the company as a liability.

*AUTHORITY: sections 354.120, 354.485, **and** 374.045**,** [and 380.561,] RSMo [1986] **2016**. This rule was previously filed as 4 CSR 190-11.010. Original rule filed June 12, 1970, effective July 1, 1970. Amended: Filed Aug. 5, 1974, effective Aug. 15, 1974. Amended: Filed July 18, 1989, effective Nov. 1, 1989. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.110 Qualifications of Actuary or Consulting Actuary. The director is amending sections (1)–(3) and (6), and amending the purpose statement.

PURPOSE: This amendment corrects a statutory reference and removes unnecessary language.

*PURPOSE: This rule describes the **necessary** qualifications [required] of an actuary signing and certifying the life and accident and health annual statement of an insurer. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implements section 376.350, RSMo.*

(1) Every life insurance company authorized to do business in this state *[is required to]* file**s** an annual statement. Missouri instructions for completing the life and accident and health annual statement blank require that these forms be signed and certified by a qualified actuary.

(2) For this purpose, a "qualified actuary" *[shall]* means a member in good standing of the American Academy of Actuaries.

(3) Scope. This rule *[shall apply]* **applies** to all reports, statements and other documents filed with the director or issued to the public in relation to the business of insurance.

(6) Annual Statements of Domestic Life Insurance Companies. Section *[376.380]* **376.350**, RSMo prescribes the general form of the annual statement which must be filed with the director each year. The form which is required by the director is that which has been developed by the National Association of Insurance Commissioners. This form now includes a requirement relating to policy reserves and other actuarial items. The instructions for completion of the blank describe the content of this requirement. The items on which actuarial opinion is required are—

*AUTHORITY: sections 374.045 and 376.350, RSMo [2000] **2016**. This rule was previously filed as 4 CSR 190-11.080. Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Amended: Filed Aug. 16, 1977, effective Dec. 11, 1977. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED RESCISSION

20 CSR 200-1.120 Take-Out Letters. This rule stated requirements for insurance companies entering into take-out letters and similar contracts to provide after-construction financing of commercial buildings. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implemented sections 376.300 and 379.080, RSMo.

PURPOSE: This rule is being rescinded because it has not been modified since its original filing in 1974 and is no longer necessary.

AUTHORITY: sections 374.045 and 379.080, RSMo Supp. 1993 and 376.300, RSMo 1986. This rule was previously filed as 4 CSR 190-11.100. Original rule filed Dec. 20, 1974, effective Dec. 30, 1974. Rescinded: Filed Oct. 30, 2018.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 1—Financial Solvency and Accounting Standards

PROPOSED RESCISSION

20 CSR 200-1.150 General Standards Applicable to Audited Financial Reports. This rule provided interpretations of various terms and provisions used in sections 375.1025—375.1062, RSMo which govern how the financial reports of insurers are to be audited.

PURPOSE: This rule is being rescinded because it largely conflicts with or duplicates Missouri statutes and is otherwise unnecessary.

AUTHORITY: sections 374.045, 375.1032, 375.1037, 375.1045, 375.013 and 375.1060 RSMo 1994. Original rule filed Aug. 11, 1992, effective May 6, 1993. Amended: Filed July 3, 1995, effective Feb. 25, 1996. Rescinded: Filed Oct. 30, 2018.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 2—Reinsurance and Assumptions

PROPOSED RESCISSION

20 CSR 200-2.200 Reinsurance—Lloyd's, London, England. This rule described conditions for reinsuring with underwriters at Lloyd's, London, England. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implemented section 375.241, RSMo.

PURPOSE: This rule is being rescinded because it implements a statute that was repealed in 1993, and because it is no longer necessary.

AUTHORITY: sections 374.045, RSMo Supp. 1993 and 375.241, RSMo 1986. This rule was previously filed as 4 CSR 190-11.070. Original rule filed July 27, 1964, effective Aug. 6, 1964. Amended:

Filed Dec. 5, 1969, effective Dec. 15, 1969. Amended: Filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded: Filed Oct. 30, 2018.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 2—Reinsurance and Assumptions

PROPOSED RESCISSION

20 CSR 200-2.700 Reinsurance Mirror Image Rule. This rule effectuated or aided in the interpretation of a law related to the business of insurance, section 375.246.5, RSMo.

PURPOSE: This rule is being rescinded because it is no longer necessary.

AUTHORITY: section 374.045, RSMo 2000. Original rule filed Aug. 20, 1993, effective May 9, 1994. Amended: filed July 12, 2002, effective Feb. 28, 2003. Rescinded: Filed Oct. 30, 2018.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 2—Reinsurance and Assumptions

PROPOSED AMENDMENT

20 CSR 200-2.800 Assumption Reinsurance. The director is removing sections (1), (2), (5), and (7), and amending existing sections (3), (4), and (6).

PURPOSE: This amendment restructures and simplifies the rule, and removes language that is unnecessary due to identical or similar statutory provisions.

[(1) Notice of transfer regarding an assumption reinsurance agreement pertaining to contracts of insurance owned by policyholders residing in the state of Missouri shall be in the form specified in section 375.1287.1(3), RSMo. The response card sent to the policyholder also shall be in the form identical to section 375.1287.1(3), RSMo.

(2) If either the transferring or the assuming insurer is a foreign insurance company and is from a state that has a reinsurance assumption law substantially similar to that of Missouri, then both insurers shall submit an affidavit stating that the transaction is subject to substantially similar requirements in their respective domiciliary states.]

*[(3)]***(1)** A summary in writing shall be submitted *[setting forth all]* **addressing each of** the factors in section 375.1287.2(5)(a)–(d) and (f), RSMo.

*[(4)]***(2)** If either the transferring insurer or the assuming insurer is a Missouri domestic, *[both insurers shall submit]* **or is from a state that does not have a reinsurance assumption law substantially similar to that of Missouri,** the following documentation **shall be submitted** to the *[Department of Insurance]* **department** for approval of the assumption:

(A) Certificate of Assumption;

(B) Copy of Notice of Transfer**, including items referenced as attachments,** and Response Card;

(C) Copy of Assumption Reinsurance Agreement and Approval from *[any]* **all** domiciliary state**s** other than Missouri;

(D) *[Ratings from the last five (5) years from two (2) nationally recognized rating services and the meaning of those ratings (if ratings are unavailable for any year of the five (5)-year period, this shall also be disclosed and explained)]* **Financial data pursuant to section 375.1287.1(2)(i), RSMo**;

[(E) Balance sheet as of December 31 for the previous three (3) years and the most recent quarterly financial statement for both the transferring insurer and the assuming insurer;]

*[(F)]***(E)** Terms and type of financing related to the purchase price; **and**

*[(G)]***(F)** Pro forma financial statements reflecting the financial condition of both insurers before and after the proposed transaction as of the effective date of the transaction*[;]***.**

[(H) Copy of the insurers' Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement; and

(I) Explanation of the reason for the transfer.

(5) If either the transferring insurer or the assuming insurer is from a state that does not have a reinsurance assumption law substantially similar to that of Missouri, then both insurers shall submit the following documentation to the Department of Insurance for approval of the assumption:

(A) Certificate of Assumption;

(B) Copy of Notice of Transfer and Response Card;

(C) Copy of Assumption Reinsurance Agreement and Approvals from domiciliary states;

(D) Ratings from the last five (5) years from two (2) nationally recognized rating services and the meaning of those ratings (if ratings are unavailable for any year of the five (5)-year period, this shall also be disclosed and explained);

(E) Balance sheet as of December 31 for the previous three (3) years and the most recent quarterly financial statement for both the transferring insurer and the assuming

insurer;

(F) Terms and type of financing related to the purchase price;

(G) Pro forma financial statements reflecting the financial condition of both insurers before and after the proposed transaction as of the effective date of the transaction;

(H) Copy of the insurers' Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement; and

(I) Explanation of the reason for the transfer.]

*[(6)]***(3)** If both the transferring insurer and the assuming insurer are domiciled in states that have assumption reinsurance laws substantially similar to those of Missouri, then *[both insurers shall submit the following documentation to the Department of Insurance:]* **the filing requirements of subsections (2)(A)–(C) of this rule apply.**

[(A) Certificate of Assumption;

(B) Copy of the Notice of Transfer and Response Card; and

(C) Copy of Assumption Reinsurance Agreement and Approvals from the domiciliary states of the transferring insurer and the assuming insurer.]

[(7) With respect to section 375.1285(5), RSMo—

(A) The term certificate shall mean the terms of a group policy as applicable to an individual insured under the group policy; and

(B) A certificate holder shall be provided notice pursuant to section 375.1287, RSMo if the certificate holder is entitled to maintain the same terms of coverage without change in benefit in the event that the group policy is terminated.]

*AUTHORITY: section 374.045, RSMo [Supp. 1993] **2016**. Original rule filed[:] Feb. 16, 1994, effective Sept. 30, 1994. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 3—Insurance Taxes Other Than Surplus Lines

PROPOSED AMENDMENT

20 CSR 200-3.010 Reporting of Flexible Payment Deferred Annuity Contract Premiums. The director is amending sections (1) and (3), and amending the purpose statement.

PURPOSE: This amendment removes unnecessary and outdated language from the rule.

*PURPOSE: This rule recognizes that flexible payment deferred annuities differ from traditional fully guaranteed fixed-premium, fixed-benefit annuity contracts in that[—] the full risk on the contract may [not] be **in**determinable and [may] not attach to the insurer[;]**,** and the total premium is not paid until it is applied to provide annuity payment. [This rule was adopted pursuant to the provisions of section 374.045, RSMo and to implement sections 148.310, 148.320, 148.330, 148.340, 148.350, 148.360, 148.370, 148.380, 148.390, 148.400, 148.410, 148.420, 148.430 and 376.350, RSMo.]*

(1) Definition. A flexible payment deferred annuity is defined as a contract which provides for the payment of a guaranteed or variable annuity**,** or both**,** with the amount of the annuity determined*[,]* not at date of issue*[,]* but at the annuity commencement date **and** by the value at that time of the total payments made. The number of these payments are not specified in the contract, but are determined by the contract holder within a range acceptable to the insurance company. These contracts may also specify guaranteed minimum nonforfeiture values and annuity rate guarantees either for the life of the contract or guaranteed lesser period. *[All these contracts must be approved by the Missouri Department of Insurance.]*

(3) Insurers Previously Reporting Under Paid-In Approach.

(B) *[Each insurer shall signify on its premium tax return covering premiums for the calendar year 1975 the method it is currently using to report premiums received under flexible payment deferred annuities.]* If an insurer using the paid-in approach subsequently adopts the pay-out approach or vice versa, it shall so signify on the premium tax return covering premiums for that calendar year.

*AUTHORITY: sections 148.310, 148.320, 148.330, 148.340, 148.350, 148.360, 148.370, 148.380, 148.390, 148.400, 148.410, 148.420, 148.430, 374.045**,** and 376.350, [RSMo 1986 and 148.360,] RSMo [Supp. 1990] **2016**. This rule was previously filed as 4 CSR 190-11.130. Original rule filed Dec. 23, 1975, effective Jan. 2, 1976. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 3—Insurance Taxes Other Than Surplus Lines

PROPOSED AMENDMENT

20 CSR 200-3.200 New Business Facility Tax Credit. The director is deleting section (2) and amending existing section (4).

PURPOSE: This amendment removes unnecessary and erroneous language from the rule.

[(2) The new business facility tax credit shall not be subject to subsection 375.916.1., RSMo, that is this credit shall not be subject to the retaliatory tax.]

*[(3)]***(2)** To the extent the amount of the new business facility tax credit exceeds the amount necessary to reduce the net Missouri premium tax due to zero (0), this excess may be applied as a credit against any retaliatory tax amount otherwise due.

*[(4)]***(3)** If an insurance company, which is also a taxpayer, has income derived from the operation of a new business facility as well as from other activities conducted with this state, the direct premiums derived by the insurance company from the operation of the new business facility *[shall be]* **is** determined by multiplying the insurance company's direct premiums, computed in accordance with Chapter 148, RSMo, by a fraction, the numerator of which is the property factor, as defined in subsection *[(4)(A)]* **(3)(A)** of this rule**,** plus the payroll factor, as defined in subsection *[(4)(B)]* **(3)(B)** of this *[section]* **rule**, and the *[demoninator]* **denominator** which is two (2)—

(A) The property factor is a fraction, the numerator of which is the new business facility investment certified for the tax period, and the denominator of which is the average value of all the taxpayer's real and depreciable tangible personal property owned or rented and used in this state during the tax period. The average value of all this property *[shall be]* **is** determined as provided in Chapter 32, RSMo; and

(B) The payroll factor is a fraction, the numerator of which is the total amount paid during the tax period by the taxpayer for compensation to persons qualifying as new business facility employees, as determined by section 135.110.4., RSMo at the new business facility, and the *[demoninator]* **denominator** of which is the total amount paid in this state during the tax period by the taxpayer for compensation. The compensation paid in this state *[shall be]* **is** determined as provided in Chapter 32, RSMo. For the purpose of this section, other activities conducted within this state *[shall]* include activities previously conducted at any time during the tax period immediately prior to the tax period in which commencement of commercial operations occurred.

*AUTHORITY: sections 135.150[, RSMo Supp. 1991] and 374.045, RSMo [1986] **2016**. Original rule filed June 18, 1993, effective Jan. 1, 1994. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 4—Record Retention for Financial Audits

PROPOSED AMENDMENT

20 CSR 200-4.010 Books, Records, Accounts and Vouchers. The director is amending sections (1), (2), and (4), and amending the purpose statement.

PURPOSE: This amendment updates the rule to comport with modern record formats and retention capabilities.

*PURPOSE: This regulation describes the requirements for recordkeeping for insurance companies and related entities doing business in this state. This regulation was adopted pursuant to the provisions of section 374.045, RSMo [1986] **2016** and to implement sections **144.027,** 287.350, 354.190, 354.465, **354.717,** 374.190, **374.205,** 374.210, **375.149, 375.150, 375.151, 375.938, 375.1009, 376.1082,** 379.343 and 379.475, RSMo [1986 and 144.027, 354.149, 354.717, 375.150, 375.151, 375.926 and 375.938 RSMo (Cum. Supp. 1991)] **2016**.*

(1) Records *[Required]* **to be Maintained** for Purposes of Financial Examinations. Every *[insurer, which term shall include every]* domestic insurer, foreign insurer, health services corporation, health maintenance organization, prepaid dental plan, managing general agent**,** and third-party administrator licensed to do business in this state shall maintain its books, records, documents**,** and other business records in an order that the insurer's financial condition may be readily ascertained by the *[Department of Insurance]* **department**, taking into consideration other record retention requirements. All **such** records must be maintained for not less than three (3) years**, or, for domestic insurers, health services corporations, health maintenance organizations, and prepaid dental plans, until the full-scope financial examination reviewing the time period that the record relates to is closed, whichever is longer**.

(2) Form of Record. *[Photographs, microfilms]* **Electronic** or other image-processing reproductions of records shall be equivalent to the originals and may be certified as same in actions or proceedings before the *[Department of Insurance]* **department** unless inconsistent with *[20 CSR 800-1.100]* **department rules governing the action or proceeding**. However, the maintenance *[or]* **of** records in a computer-based format shall be archival in nature only, so as to preclude the possibility of alteration of the contents of the record by computer after the initial transfer of the record to this format. In addition, all records must be capable of duplication to hard copy upon the request of a financial examiner.

(4) Time Limits. The insurer shall provide, within five (5) working days, any record requested by any duly appointed financial examiner of the director conducting an on-site financial examination. When the requested record is not or cannot be produced by the insurer within five (5) working days, the nonproduction *[shall be deemed a violation of]* **violates** this rule, unless the insurer can demonstrate to the satisfaction of the director that there is a reasonable justification for that delay.

*AUTHORITY: sections **144.027,** 287.350, 354.190, 354.465, **354.717,** 374.045, 374.190, **374.205,** 374.210, **375.149, 375.150, 375.151, 375.938, 375.1009, 376.1082,** 379.343 and 379.475, RSMo [1986] **2016** [and 144.027, 354.717, 375.149, 375.150, 375.151, 375.926 and 375.938, RSMo Supp. 1991]. This rule was previously filed as 4 CSR 190-11.050. Original rule filed Dec. 20, 1974, effective Dec. 30, 1974. Amended: Filed Sept. 5, 1975, effective Sept. 15, 1975. Amended: Filed April 4, 1991, effective Oct. 31, 1991. Amended: Filed Oct. 30, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 5—Articles and Bylaws of Domestic Insurers

PROPOSED AMENDMENT

20 CSR 200-5.010 Amendment and Restatement of Articles. The director is amending sections (1) and (2), and deleting the two (2) appendices that follow the rule.

PURPOSE: This amendment simplifies and modernizes the rule, and amends the rule to provide for a streamlined process to amend and restate articles of incorporation or association.

(1) Forms.

*[(A) FORM5.DOC shall be the f]***Form****s to be** used by any insurance company organized or incorporated under the laws of this state to amend**, restate, or amend and restate** its articles of incorporation or association, if that company is subject to sections 375.201–*[375.221]* **375.226**, RSMo**, are available on the department's website or by contacting the department**.

[(B) FORM7.DOC shall be the form used by any insurance company organized or incorporated under the laws of this state to restate its articles of incorporation or association, if that company is subject to section 375.226, RSMo.

(C) Any insurance company organized or incorporated under the laws of this state and subject to sections 375.201-375.226, RSMo which amends and restates its articles of incorporation or association shall first amend its articles using FORM5.DOC and then restate its articles as amended using FORM7.DOC.

(D) Copies of FORM5.DOC and FORM7.DOC may be obtained from the Admissions Specialist, Financial Examination Section. Copies may be freely duplicated. Appendices 1 and 2, as they appear in this rule, are representative of FORM5.DOC and FORM7.DOC, respectively, but are not in a form suitable for filing.]

(2) Procedures.

(C) Amending and restating the articles of incorporation or association of an insurance company organized or incorporated under the laws of this state may be accomplished simultaneously.

AUTHORITY: section 374.045[.1(2)], RSMo [Supp. 1998] ***2016****. This rule was previously filed as 4 CSR 190-11.330. Original rule filed Sept. 18, 1990, effective Feb. 14, 1991. Amended: Filed Jan. 8, 1991, effective June 10, 1991. Amended: Filed April 23, 1999, effective Nov. 30, 1999. Amended: Filed Oct. 30, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 17—Admissions

PROPOSED AMENDMENT

20 CSR 200-17.200 Procedure for Foreign Insurer to Obtain a Certificate of Authority to Transact the Business of Insurance. The director is amending sections (1) and (3).

PURPOSE: This amendment removes outdated language.

(1) Any foreign insurance company, as that term is used in section 375.811, RSMo, making application to the director of the *[Department of Insurance]* **department** for a certificate of authority to transact an insurance business in the state of Missouri shall do so by filing both of the following:

(B) Additional information as follows:

[1. A letter from the insurance commissioner of the applicant's domicile state stating that according to his/her records, the applicant is prompt and equitable in its loss payments to policyholders and payments are in accordance with policy provisions;]

*[2.]***1.** A narrative description of the history of the applicant;

*[3.]***2.** Explanation of any unique assets, liabilities**,** or operating aspects of the applicant; and

*[4.]***3.** A detailed explanation of any present controversy with any state or federal regulatory agency or of any presently pending formal or informal hearings.

(3) Upon request, the *[Missouri Department of Insurance]* **department** will provide information regarding:

AUTHORITY: section 374.045, RSMo [2000] ***2016****. Original rule filed June 14, 2001, effective Dec. 30, 2001. Amended: Filed Oct. 30, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 19—Discount Medical Plans

PROPOSED AMENDMENT

20 CSR 200-19.020 Scope and Definitions. The director is amending

sections (1) and (2).

PURPOSE: This amendment updates and removes unnecessary language.

(1) *[Applicability of Rules.]* The rules in this chapter apply to discount medical plan organizations transacting business under sections 376.1500 to 376.1532, RSMo. The rules *[shall]* **are to** be read together with Chapter 536, RSMo.

(2) *[Definitions.]* **The definitions located in section 376.1500, RSMo apply to the rules in this chapter.**

[(A) "Director," the director of the department;

(B) "Department," the department of insurance, financial institutions and professional registration.]

*AUTHORITY: sections 374.045[, RSMo 2000] and [section] 376.1528, RSMo [Supp. 2007] **2016**. Original rule filed Nov. 1, 2007, effective June 30, 2008. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 200—Insurance Solvency and Company Regulation
Chapter 19—Discount Medical Plans

PROPOSED AMENDMENT

20 CSR 200-19.050 Registration. The director is amending sections (1)–(3).

PURPOSE: This amendment modifies and removes unnecessary language.

(1) Registration Forms. The following form has been adopted and approved for filing with the department:

(A) The Discount Medical Plan Organization Registration form (Form DM-1)*[, or any form which substantially comports with the specified form]*.

(2) Application and Fees.

(A) Initial Registration. Each *["]*discount medical plan organization*[," as that term is used in sections 376.1500 to 376.1532, RSMo,]* shall register with the director by:

1. *[Completing]* **Completion** and filing **of** a Form DM-1 in accordance with the instructions contained therein;

2. Payment of **the** two hundred fifty dollar ($250) registration fee; and

3. Demonstration of compliance with **the** net worth requirement under rule 20 CSR 200-19.060.

(B) Renewal Registration. Each discount medical plan organization *[shall]* **may** renew its registration between thirty (30) days prior to and the anniversary date of its initial registration by*[:]*—

1. *[Submitting]* **Submission of** any amendments to the Form DM-1;

2. Payment of **the** two hundred fifty dollar ($250) annual registration fee; and

3. Demonstration of compliance with **the** net worth requirement under rule 20 CSR 200-19.060.

(3) Copies of the Form DM-1 may be obtained from *[the director at the department's office in Jefferson City, Missouri, on]* the department's web site, www.insurance.mo.gov *[or by mailing a written request to the department at Attention: Admissions Specialist, Department of Insurance, Financial Institutions and Professional Registration, PO Box 690, Jefferson City, MO 65102]*.

*AUTHORITY: sections 374.045, [RSMo 2000 and sections] 376.1504, and 376.1528, RSMo [Supp. 2007] **2016**. Original rule filed Nov. 1, 2007, effective June 30, 2008. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 400—Life, Annuities and Health
Chapter 6—Health Services Corporations

PROPOSED AMENDMENT

20 CSR 400-6.100 Establishment and Computation of Reserves. The director is amending sections (2) and (3), and amending the purpose statement.

PURPOSE: This amendment removes outdated language.

PURPOSE: This regulation describes the method of establishment and computation of reserves for health services corporations. This regulation is adopted pursuant to section 354.120, RSMo [1986] and to implement section 354.080, RSMo [1986].

(2) Factors to be Considered in Reducing this Reserve Requirement.

(A) The primary consideration in any reductions of reserves *[must]* **will** be the security for payment of the benefits stated in the membership contract. Any factors which would provide security for payment comparable to the reserve *[shall]* **will** be considered.

(3) Reduction of Reserves.

[(A)] Any health service corporation subject to Chapter 354, RSMo may petition the director *[of insurance]* to reduce *[or suspend]* the *[financial reserves required by]* section 354.080, RSMo **financial reserve requirements pursuant to section 374.055, RSMo**. *[The*

director shall give ten (10) days' notice of the hearing to the petitioning corporation and hear the matter pursuant to the provisions of 20 CSR 800-1.010.]

[(B) The director shall issue an order subsequent to the hearing based upon the best interests of the members and beneficiaries of the petitioning corporation. The order must state the factual bases and any other factors considered in permitting or refusing any decrease or suspension of reserve requirements.]

*AUTHORITY: sections 354.080 and 354.120, RSMo [1986] **2016**. This rule was previously filed as 4 CSR 190-15.010. Original rule filed Sept. 19, 1974, effective Sept. 29, 1974. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 500—Property and Casualty
Chapter 10—Mortgage Guaranty Insurance

PROPOSED RESCISSION

20 CSR 500-10.100 Definitions. This rule defined terms and explained usage for those terms used in this chapter. This regulation implemented section 379.010, RSMo.

PURPOSE: This rule is being rescinded because it is unnecessary.

AUTHORITY: sections 374.045, RSMo 2000 and 443.415, RSMo Supp. 2002. Original rule filed April 11, 1996, effective Nov. 30, 1996. Amended: Filed Aug. 31, 2000, effective April 30, 2001. Amended: Filed Nov. 1, 2002, effective July 30, 2003. Rescinded: Filed Oct. 30, 2018.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 500—Property and Casualty
Chapter 10—Mortgage Guaranty Insurance

PROPOSED RESCISSION

20 CSR 500-10.200 Financial Regulation. This rule defined terms and explained usage for those terms used in this chapter. This regulation implemented section 379.010, RSMo.

PURPOSE: This rule is being rescinded because it is unnecessary.

AUTHORITY: section 374.045, RSMo Supp. 2009. Original rule filed April 11, 1996, effective Nov. 30, 1996. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed April 15, 2010, effective Dec. 30, 2010. Rescinded: Filed Oct. 30, 2018.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 500—Property and Casualty
Chapter 10—Mortgage Guaranty Insurance

PROPOSED RESCISSION

20 CSR 500-10.300 Unfair Acts or Practices. This rule carried out and effectuated the provisions of sections 375.930-375.948, RSMo (1994), as such sections apply to mortgage guaranty insurance.

PURPOSE: This rule is being rescinded because it is not supported by the authorizing statute.

AUTHORITY: section 375.948, RSMo 1994. Original rule filed April 11, 1996, effective Nov. 30, 1996. Amended: Filed Aug. 31, 2000, effective April 30, 2001. Rescinded: Filed Oct. 30, 2018.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Kelly A. Hopper, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 500—Property and Casualty
Chapter 10—Mortgage Guaranty Insurance

PROPOSED RESCISSION

20 CSR 500-10.400 Policy Rates and Forms. This rule effectuated sections 379.420 to 379.510, RSMo (1994), as such sections applied to mortgage guaranty insurance.

PURPOSE: This rule is being rescinded because it is unnecessary.

AUTHORITY: section 374.045, RSMo 1994. Original rule filed April 11, 1996, effective Nov. 30, 1996. Rescinded: Filed Oct. 30, 2018.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 800—Administrative Procedures under the Insurance Laws
Chapter 3—Mergers and Acquisitions

PROPOSED AMENDMENT

20 CSR 800-3.010 Definitions. The director is amending sections (1) and (2).

PURPOSE: This amendment updates the rule to reflect an additional type of merger and acquisition proceeding, clarifies language, and removes unnecessary definitions.

(1) Applicability of Rules. The rules in this chapter apply to all hearings conducted pursuant to the merger and acquisition review procedures in sections 375.355 *[and]***,** 382.060, **and 382.095,** RSMo and are governed by Chapter 536, RSMo. The rules *[shall]* **are to** be read together with Chapter 536, RSMo.

(2) Definitions.

[(A) *"Certificate of Authority" the whole or part of any certificate of approval or charter granted by the director for any insurance company, insurer, association, health services corporation, health maintenance organization, or other legal entity insuring risk.]*

*[(B)]***(A)** "Director" the director of the department.

*[(C)]***(B)** "Department" means the Department of Insurance, Financial Institutions and Professional Registration.

*[(D)]***(C)** "Party" any individual, partnership, corporation, association, public or private organization of any character or any other governmental agency properly requesting a hearing, named as a respondent, seeking to be heard or entitled to intervene in any matter under the rules in this chapter. **Any division of the department is entitled to act as a party in any matter under the rules of this chapter.**

[(E) "Respondent" any party in an administrative proceeding before the director under sections 375.355 and 382.060, RSMo.]

*AUTHORITY: section 374.045, RSMo [2000] **2016**. Original rule filed Sept. 5, 2007, effective May 30, 2008. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 800—Administrative Procedures under the Insurance Laws
Chapter 3—Mergers and Acquisitions

PROPOSED AMENDMENT

20 CSR 800-3.020 General Procedures. The director is amending sections (1) and (2) and (4)–(9).

PURPOSE: This amendment clarifies and modernizes the rule.

(1) Rules of Procedure. The hearings before the director pursuant to sections 375.355 *[and]***,** 382.060, **and 382.095,** RSMo are governed by **the rules of this chapter, the rules of Division 800, Chapter 1 concerning contested case proceedings, and** Chapter 536, RSMo.

(2) Place of Filing. If the matter is to be heard by the director, all pleadings, documents**,** and requests *[permitted or required]* to be filed with the department in connection with a hearing shall be delivered, mailed, addressed**,** or submitted to or filed with the director at the Department of Insurance, Financial Institutions and Professional Registration, PO Box 690, 301 West High Street, Jefferson City, MO 65102. The party filing pleadings or documents shall serve by mail copies of all filed pleadings or documents on all parties.

(4) Form of Documents.

(A) Except as otherwise provided, one (1) original and *[four (4)]* **two (2)** copies of all documents **initiating proceedings** shall be signed by the party or by his/her authorized representative or attorney and filed with the director.

(5) Computation of Time.

(A) In computing any period of time prescribed or allowed by this regulation or by any applicable statute, the day of the act, event**,** or default after which the designated period of time begins to run is not to be included. The last day of the period so computed is to be included, unless it is a Saturday, Sunday**,** or legal holiday, in which event the period runs until the end of the next day that is neither a Saturday, Sunday**,** nor a legal holiday. When the period of time prescribed or allowed is less than seven (7) days, intermediate Saturdays,

Sundays**,** and legal holidays *[shall be]* **are** excluded in the computation.

(B) Notice requirements *[shall be]* **are** construed to mean notice received, but proof that notice was dispatched by means reasonably calculated to be received by the prescribed date *[shall be]* **is** prima facie evidence that notice was timely received.

(6) Appearance.

(A) Any person entitled to participate in any proceedings may appear as follows:

1. A natural person may appear on his/her own behalf or by an attorney at law licensed to practice in Missouri or both; *[and]*

2. A division of the department may appear by an attorney at law licensed to practice in Missouri; and

*[2.]***3.** A corporation, association**,** or other entity shall be represented by an attorney licensed to practice in Missouri, except a bona fide officer, employee**,** or representative may appear on behalf of such entities for preliminary matters until such time as an attorney is retained.

(C) An attorney appearing in a representative capacity shall file a written *[notice]* **entry** of appearance.

(7) Presiding Officer. The director has the authority to conduct a hearing, take all necessary action to avoid delay, maintain order**,** and insure the development of a clear and complete record. The director possesses all powers necessary to conduct a hearing including, but not limited to, the power to—

(B) Regulate the course of hearings, set the time and place for continued hearings, fix times for filing of documents, provide for the taking of testimony by deposition if necessary**,** and generally conduct the proceedings according to generally recognized administrative law and this regulation;

(C) Examine witnesses and direct witnesses to testify, limit the number of times any witness may testify, limit repetitious or cumulative testimony**,** and set reasonable limits on the amount of time each witness may testify;

(E) Sign and issue subpoenas that require attendance giving testimony and the production of books, papers**,** and other documentary evidence;

(H) Render findings of fact, conclusions of law, decisions**,** and orders;

(I) Order the filing of written direct testimony by *[all parties]* **any party** to a hearing. Written direct testimony, if ordered to be filed, shall be on eight and one-half inch by eleven inch (8 1/2" × 11") paper, in question and answer form and the truth sworn to before a notary public. *[Written direct testimony, if ordered to be filed, shall be in lieu of all live direct testimony except redirect or rebuttal testimony or if good cause is shown to the director.]* The right to cross-examination of any witness on whose behalf written direct testimony is filed is mandatory; and

(8) Transcription of Proceedings.

(A) Oral proceedings at which evidence is presented *[shall]* **will** be recorded *[either]* **and transcribed** by a certified court reporter *[or a mechanical recording device, but need not be transcribed unless requested by a party who shall pay for the transcription of the portion requested]*, except as otherwise provided by law. Any transcription will be retained through and including the time allotted for appeal, revision, rehearing**,** or other manner of review prior to final disposition as provided for by law.

(B) The transcript and the record offered in connection with the hearing *[shall]* constitute the official record. *[Before the transcript is filed, the director shall notify the parties that the transcript has been produced, receive corrections from any person, examine the transcript for accuracy and then within a reasonable time certify that it is a true and correct transcript of the hearing. Only after the certification may the transcript be made available for public inspection as the director may allow.*

[C)] The record in an administrative hearing shall include: prehearing records; all pleadings (including all notices and answers, motions, and briefs); evidence received; a statement of matters officially noticed; offers of proof, objections**,** and rulings; all orders entered by the director; and findings, conclusions, opinions, recommendations**,** and final order of the director.

(9) Existing Statutory or Department Procedures and Practices. This regulation *[shall]* **is** not **to** be construed to limit or repeal additional requirements imposed by statute or otherwise or to change existing department procedures which are equivalent to or exceed the standards of administrative procedure prescribed in this regulation.

*AUTHORITY: section 374.045, RSMo [2000] **2016**. Original rule filed Sept. 5, 2007, effective May 30, 2008. Amended: Filed Oct. 30, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2070—State Board of Chiropractic Examiners
Chapter 3—Preceptorship

PROPOSED RESCISSION

20 CSR 2070-3.010 Preceptorship. This rule allowed preceptorship programs by approved chiropractic colleges and explained the allowable activities by interns.

PURPOSE: This rule is being rescinded because chiropractic colleges and universities are responsible for selecting and screening preceptors for chiropractic students, therefore the rule is no longer necessary.

*AUTHORITY: section 331.100.2, RSMo 2000. This rule originally filed as 4 CSR 70-3.010. Original rule filed April 16, 1990, effective June 30, 1990. For intervening history, please consult the **Code of State Regulations**. Rescinded: Filed Oct. 23, 2018.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the State Board of Chiropractic Examiners, PO Box 672, Jefferson City, MO 65102-0672, by facsimile at (573) 751-0735, or via email at chiropractic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 1—General Organization

PROPOSED RULE

22 CSR 10-1.030 Board of Trustees Election Process

PURPOSE: This rule establishes the policy of the board of trustees in regard to election of board members by the subscribers of the Missouri Consolidated Health Care Plan.

(1) The subscribers of the Missouri Consolidated Health Care Plan (MCHCP) shall elect two (2) active employee members and one (1) retiree member to the board of trustees. Each member will serve a term of four (4) years from the first day of January following their election.

(2) Board Member Candidate Eligibility.

(A) Candidates must be a subscriber of the plan.

(B) A candidate who is running for a position on the board as an active employee member must be employed on the date the nominating petitions are due. Failure to be employed at that time will result in an automatic disqualification.

(C) A candidate who is running for a position on the board as a retiree member must be retired on the date that the nominating petitions are due. Failure to be retired at that time will result in an automatic disqualification.

(D) The following members are not eligible candidates:

1. Current employees of the plan;

2. Immediate relatives of persons employed by the plan. Immediate relatives include:

A. Employee's spouse;

B. Children of employee or spouse;

C. Parents of employee or spouse;

D. Brothers and sisters of employee, including brothers-in-law and sisters-in-law;

E. Grandchildren (including great-grandchildren) of employee or spouse;

F. Grandparents (including great-grandparents) of employee or spouse; and

G. Members of the employee's household.

(E) It will be automatic grounds for disqualification if it is determined that a candidate knowingly submitted false information in the election process.

(3) Nomination Process.

(A) Candidates will be nominated by means of a nominating petition.

(B) The plan will notify subscribers of an opening for a board position.

(C) Candidates may only run for one (1) position on the board.

(D) Candidates must download from MCHCP's website, complete, and submit in a manner indicated by the plan, a valid nominating petition by a date determined by the plan. Valid nominating petitions include:

1. Candidate Information, including but not limited to, name, department, and resume;

2. Information to solicit the candidate's interest in health care issues;

3. Information to solicit any disqualifying information of the candidate;

4. A summary of information regarding the candidate's background and qualifications, for example: years of state service, department experience, and reasons for wanting to be on the board. The summary shall not to exceed three hundred (300) words and will be used on the voting website. Formatting of this information for the board election ballot materials will be under the direction of the plan; and

5. Any additional information as determined by the plan which is important to the nominating and voting process.

(E) Board member candidates may not use state resources (equipment, personnel, and supplies) for campaign purposes. Board member candidates may not use interagency mail or send email from a computer provided by the state to distribute campaign materials. State agencies, at their discretion, may allow the posting of campaign materials provided by the candidates on an equal time basis.

(F) Board candidates may not use the plan's resources for campaign purposes. This includes receiving demographic information of the plan's members, including but not limited to, member names, phone numbers, addresses, and email addresses.

(G) The plan will establish procedures to ensure candidate information is true and accurate. These procedures will include, but may not be limited to, validation of the information on the candidate petition forms.

(H) If only one (1) valid nominating petition is filed for any vacancy, the person nominated will be declared elected by the board at the next regular board meeting.

(I) If at least one (1) valid nominating petition is not filed for each vacancy to be filled, this election process shall be repeated for that vacancy until a valid nominating petition is received.

(4) Election Ballots and Results.

(A) The plan will notify members of an election voting period in advance of the start of the voting period in the year of the board election.

(B) The voting period will be at least fourteen (14) calendar days in length. The beginning date of the voting period will be set by MCHCP's Executive Director.

(C) Voters must be a subscriber of the plan as of the last day of the month preceding the month in which the election is to be held.

(D) Names of candidates will be listed on the website or in a supplemental publication in random order at the discretion of the plan. In no event will names of candidates be placed in alphabetical order on the election ballot or in a supplemental publication other than by happenstance.

(E) All board election voting will be completed through the eligible subscriber's myMCHCP account. Access to computers for voting use will be available at MCHCP during normal business hours. Ballots not submitted through a myMCHCP account are invalid. An eligible subscriber may only vote once per election.

(F) Voting will cease at midnight Missouri time on the last day of the board election.

(G) Ballots for an active employee member election will allow selection of one (1) or two (2) active employee member candidates to become board members depending on the number of positions up for election. If the election is for two (2) board positions, the two (2) candidates receiving the highest number of votes will be declared elected. If the election is for one (1) board position, the candidate receiving the highest number of votes will be declared elected. If a tie occurs between two (2) or more candidates receiving an identical number of votes, the winner shall be determined by a toss of a coin.

(H) Ballots for retiree members will allow selection for one (1) retiree member candidate to become a board member. The one (1) candidate receiving the highest number of votes will be declared elected. If a tie occurs between two (2) or more candidates receiving an identical number of votes, the winner shall be determined by a toss of a coin.

(I) The Executive Director will administer any online balloting procedures, record all votes, and declare election results.

(J) The election results will be posted within forty-eight (48) hours of the official certification of the election by the plan. Voting records will be maintained by the Executive Director for a period of one (1) year. After one (1) year from the date of the certification of the results, voting information will be destroyed.

(K) Newly elected board members will begin their terms upon certification of the election.

(5) Qualifications for Board Members.

(A) The winning candidate(s) shall file a personal financial disclosure per RSMo, 103.008 within thirty (30) days of their election to the board.

(B) A board member representing active employee members must be employed on January 1 of each year following the election. Failure to be employed at that time will result in their resignation from the board.

(C) A board member representing active employee members who terminates employment with a covered agency for more than thirty (30) consecutive days while serving on the board will be considered to have resigned from the board. The election process will begin to fill the vacant seat within ninety (90) days of the resignation.

(D) A candidate who is running for a position on the board as a retiree member must be retired on January 1 of each year following the election. Failure to be retired at that time will result in an automatic disqualification.

(E) A retiree board member who becomes employed in a MCHCP benefit eligible position while serving on the board will be considered to have resigned from the board. The election process will begin to fill the vacant seat within ninety (90) days of the resignation.

(6) Vacancies. If a vacancy occurs at any time in the three (3) elected seats, election procedures will begin to take place within ninety (90) days of the vacancy.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (19), (29), (39), (51) and (52), deleting section (74), and renumbering thereafter.

PURPOSE: This amendment revises the definitions of diabetes education, essential benefits, Health Savings Account Plan, network, and non-network; removes the definition of terminated vested subscriber because it is duplicative of section (79); and renumbers as necessary.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.

(19) Diabetes *[Education]* **Self-Management/Training**. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

(29) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, *[immunizations]* **vaccinations**, preventive services, and newborn screenings.

(39) *[Health Savings Account (HSA)]* **High Deductible Health** Plan. A health plan with a higher deductible than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

(51) Network. The *[facilities,]* providers, *[and suppliers]* the health insurer**,** or plan has contracted with to provide health care services **to members**.

(52) Non-network. The *[facilities,]* providers*, [and suppliers]* the health **insurer, or** plan does not contract with to provide health care services **to members**. **Some providers may be a part of secondary provider networks recognized by the vendor for non-network benefits.**

[(74) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.]

*[(75)]***(74)** Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

*[(76)]***(75)** Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

*[(77)]***(76)** Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

*[(78)]***(77)** Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

*[(79)]***(78)** Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

*[(80)]***(79)** Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED AMENDMENT

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

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

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

(2) Eligibility Requirements.

(B) Retiree Coverage.

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

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

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

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

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

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

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

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

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

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

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

B. Active Employee Coverage of a Spouse.

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

C. Retiree Coverage of a Spouse.

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

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

2. Children.

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

(I) Natural child of subscriber or spouse;

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

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

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

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

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

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

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

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

(X) *[A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.]* **Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or**

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

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(G), may be

covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

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

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

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

(3) Enrollment Procedures.

(A) Active Employee Coverage.

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

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

3. An active employee may *[apply for]* **elect or change** coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

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

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

4. Default enrollment.

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

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

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

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

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

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

(B) Retiree Coverage.

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

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

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

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

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

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

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

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

(II) Eligibility for employer-sponsored coverage ends;
(III) Employer contributions toward the premiums end; or
(IV) COBRA coverage ends.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C)*[.]* Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

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

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

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

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

3. Default enrollment.

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

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

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

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

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

the next calendar year.

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

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

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

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

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

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

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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

3. Default enrollment.

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

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

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

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

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

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

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

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

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

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

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

(E) Survivor Coverage.

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

day of the month after the death of the employee.

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

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

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

2. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

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

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

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

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

4. Default enrollment.

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

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

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

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

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

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

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

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

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

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

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

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

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

(G) Disabled Dependent.

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

A. Evidence from the Social Security Administration (SSA)

that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

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

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

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

(8) Voluntary Cancellation of Coverage.

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

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

(9) Continuation of Coverage.

(A) Leave of Absence.

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

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

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

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

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

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending sections (6) and (7).

PURPOSE: This amendment revises the Missouri Consolidated Health Care Plan contribution methodology for retiree coverage; removes language related to the Medicare Prescription Drug Only Plan; and renumbers as necessary.

(6) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward retiree coverage is based on either of the following:

(A) *[It]* **The contribution percentage** is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%), or in other words the retiree's years of service is capped at twenty-six (26) years. *[For Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium. In addition, for Medicare retirees covering dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. For non-Medicare retirees, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%)*

multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount the MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. The above calculations can be written by formula as follows:]

[1. Medicare Retiree MCHCP contribution = (2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium) + Medicare Retiree MCHCP dependent contribution (if any);

2. Non-Medicare Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium with tobacco-free incentive and the partnership incentive + Non-Medicare Retiree MCHCP dependent contribution (if any);

3. Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium at the rate tier the retiree has selected – Retiree only PPO 600 Plan total premium)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected; or

4. Non-Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium with tobacco-free incentive and partnership incentive at the rate tier the retiree has selected – Retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected;]

1. Medicare retirees.

A. For Medicare retirees, the contribution percentage is multiplied by the retiree only Medicare Advantage Plan total premium. The resulting product is the MCHCP contribution, which shall be subtracted from the Medicare Advantage total premium. The difference is the amount of the retiree contribution toward the total premium.

B. For Medicare retirees covering Medicare-eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the Medicare Advantage premium, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

C. For Medicare retirees covering non-Medicare eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the difference in premium of the retiree only Medicare Advantage Plan and the premium of the dependent portion of the PPO 1250 Plan at the rate tier the retiree has selected, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

2. Non-Medicare retirees.

A. For non-Medicare retirees, the contribution percentage is multiplied by the retiree only PPO 1250 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

B. For non-Medicare retirees covering Medicare-eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the Medicare Advantage premium, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

C. For non-Medicare retirees covering non-Medicare eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: contribution percentage multiplied by the difference in premium of the retiree only PPO 1250 Plan total premium with tobacco-free incentive and partnership incentive and the premium of the PPO 1250 Plan at the rate tier the retiree has selected, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection *[(3)]***(6)**(A) is compared to the flat dollar amount that was contributed for the same rate tier in 2002. The retiree's subsidy is the greater of the amount calculated in subsection *[(3)]***(6)**(A) or the flat dollar amount that was contributed in 2002.

[(7) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree and survivor premium for members enrolled in the Medicare Prescription Drug Only Plan is based on either of the following:

(A) The subsidy is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by MOSERS or PSRS multiplied by two and one half percent (2.5%), and capped at sixty-five percent (65%). The computed percentage is multiplied by the Medicare Prescription Drug Only Plan premium at the rate tier the retiree selected. The resulting product is the MCHCP contribution, which shall be subtracted from the total Medicare Prescription Drug Only Plan premium. The difference is the amount of the retiree contribution toward the Medicare Prescription Drug Only Plan premium. The above calculation can be written by formula as follows: Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Medicare Prescription Drug Only Plan premium; or

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (7)(A) is compared to fifty-nine percent (59%) of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (7)(A) or fifty-nine percent (59%) of the Medicare Prescription Drug Only Plan.]

*[(8)]***(7)** Premium. Payroll deductions, Automated Clearing House (ACH) transactions, debit cards, credit cards, and/or direct bills are processed by MCHCP.

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

3. If a subscriber owes premiums outside the current month, payroll deductions for all other premiums owed will be divided equally and taken from the subscriber's future payrolls as follows:

A. Fifty dollars ($50) or less, deduction will be taken from one (1) payroll;

B. Fifty-one dollars ($51) to one hundred dollars ($100) will be deducted from two (2) payrolls;

C. One hundred one dollars ($101) to two hundred dollars

($200) will be deducted from three (3) payrolls;

D. Two hundred one dollars ($201) to three hundred dollars ($300) will be deducted from four (4) payrolls;

E. Three hundred one dollars ($301) to four hundred dollars ($400) will be deducted from five (5) payrolls;

F. Four hundred one dollars ($401) to five hundred dollars ($500) will be deducted from six (6) payrolls;

G. Five hundred one dollars ($501) to six hundred dollars ($600) will be deducted from seven (7) payrolls;

H. Six hundred one dollars ($601) to seven hundred dollars ($700) will be deducted from eight (8) payrolls;

I. Seven hundred one dollars ($701) to eight hundred dollars ($800) will be deducted from nine (9) payrolls;

J. Eight hundred one dollars ($801) to nine hundred dollars ($900) will be deducted from ten (10) payrolls;

K. Nine hundred one dollars ($901) to one thousand dollars ($1,000) will be deducted from eleven (11) payrolls; and

L. One thousand one dollars ($1,001) and over will be deducted from twelve (12) payrolls.

4. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(B) Active Employee Whose Payroll Information is not Housed in the SAM II Human Resource System.

1. Premium payroll deductions are submitted to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If a subscriber owes past-due premiums, payroll deductions for current premiums along with the payroll deductions for past-due premiums may be taken at the discretion of the employer.

2. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deductions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit check deduction is taken for October medical, dental, and vision premiums).

2. If a retiree or survivor is currently having deductions taken from his/her benefit check and owes past-due premiums due to a change in his/her deductions, MCHCP will contact MOSERS to determine if the benefit check is large enough to cover the past-due premiums. If the benefit check is large enough to cover the past-due premiums, deductions will be divided and taken from the retiree or survivor's next three (3) benefit checks and coverage will be continuous. If the retiree or survivor's benefit check is not large enough to cover the deductions, and the retiree or survivor has failed to make the necessary premium payments, coverage will be terminated due to nonpayment, effective the last day of the month a full premium was received.

(D) Direct Bill of Premium Owed By Subscribers Whose Premium is not Deducted from Payroll or Benefit Check.

1. Premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

2. A subscriber may elect to pay premiums by ACH electronic payment. In that case, the subscriber agrees that he/she will not receive a monthly bill.

A. Premiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental, and vision premiums).

B. If there are insufficient funds, MCHCP will bill the subscriber for the premium owed. The due date of the premium owed shall not change due to insufficient funds.

*[(9)]***(8)** Premium Payments.

(A) By enrolling in coverage under MCHCP, an active employee agrees that MCHCP may deduct the member's contribution toward the total premium from the subscriber's paycheck. Payment for the first month's premium is made by payroll deduction. Subsequent premium payments are deducted from the active employee's paycheck. If the active employee's check is not sufficient to cover his/her premium, the active employee agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP.

(B) By enrolling in coverage under MCHCP, the retiree or survivor agrees that MCHCP will automatically deduct the premium from the retiree or survivor's benefit check. The retiree or survivor may choose to receive a monthly bill in lieu of an automatic deduction. If the retiree or survivor's deduction is not sufficient to cover his/her premium or the retiree or subscriber chooses to receive a monthly bill, the retiree or survivor agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP.

(C) If the subscriber fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received. The subscriber is responsible for claims submitted after the termination date.

1. If a non-Medicare subscriber fails to pay premiums by the required due date, MCHCP allows a thirty-one- (31-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, coverage will be retroactively terminated on the last day of the month for which full premium payment was received. The subscriber will be responsible for the value of the services rendered after the retroactive termination date, including, but not limited to, the grace period.

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

*[(10)]***(9)** Refunds of overpayments are limited to the amount overpaid during the twelve- (12-) month period ending at the end of the month preceding the month during which notice of overpayment is received by MCHCP.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in

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

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

PROPOSED AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan amending section (1).

PURPOSE: This amendment adds preauthorization requirements for chemotherapy for cancer diagnosis, dialysis, and specialty injectibles; revises preauthorization requirements for surgery (outpatient); alphabetizes the list of medical services, and renumbers as necessary.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, *[including,]* **or who are enrolled in the** Medicare*[,]* **Advantage Plan** are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorization does not verify eligibility or payment. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to preauthorization:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service;

D. Auditory brainstem implant (ABI);

E. Bariatric surgery;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chelation therapy;

H. Chemotherapy for cancer diagnosis;

*[G.]***I.** Chiropractic services after twenty-six (26) visits annually;

*[H.]***J.** Cochlear implant device;

[I. Chelation therapy;]

*[J.]***K.** Dental care;

L. Dialysis

*[K.]***M.** Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

*[L.]***N.** Genetic testing or counseling;

*[M.]***O.** Hearing Aids;

*[N.]***P.**Home health care;

*[O.]***Q.** Hospice care and palliative services;

*[P.]***R.** Hospital inpatient services;

*[Q.]***S**.Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

*[R.]***T.** Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

*[S.]***U.** Nutritional counseling after six (6) sessions annually;

*[T.]***V.**Orthognathic surgery;

*[U.]***W.** Orthotics over one thousand dollars ($1,000);

*[V.]***X.** Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per calendar year;

*[W.]***Y.** Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

*[X.]***Z.** Prostheses over one thousand dollars ($1,000);

*[Y.]***AA**. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

*[Z.]***BB**. Skilled nursing facility;

CC. Specialty injectables;

*[AA.]***DD.** Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), **total hip arthroplasty, total knee arthroplasty,** and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

*[BB.]***EE.** Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

AUTHORITY: section 103.059, RSMo [2000] ***2016****. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the* ***Code of State Regulations****.*

Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

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

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

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

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

PROPOSED RULE

22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, seven hundred fifty dollars ($750); family, one thousand five hundred dollars ($1,500) and for non-network: per individual, one thousand five hundred dollars ($1,500); family, three thousand dollars ($3,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, two thousand two hundred fifty dollars ($2,250); family, four thousand five hundred dollars ($4,500) and for non-network: per individual, four thousand five hundred dollars ($4,500); family, nine thousand dollars ($9,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars ($25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans during the plan year or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments.

(A) Emergency room—two hundred fifty dollars ($250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(B) Inpatient hospitalization—two hundred dollars ($200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

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

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

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

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

PROPOSED RULE

22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1250 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, one thousand two hundred fifty dollars ($1,250); family, two thousand five hundred dollars ($2,500) and for non-network: per individual, two thousand five hundred dollars ($2,500); family, five thousand dollars ($5,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable

for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, three thousand seven hundred fifty dollars ($3,750); family, seven thousand five hundred dollars ($7,500) and for non-network: per individual, seven thousand five hundred dollars ($7,500); family, fifteen thousand dollars ($15,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars ($25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager systems, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled, the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars ($25); mental health: twenty-five dollars ($25); specialist: forty dollars ($40); chiropractor office visit and/or manipulation: the lesser of twenty dollars ($20) or fifty percent (50%) of the total cost of services; urgent care: fifty dollars ($50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—two hundred fifty dollars ($250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(C) Inpatient hospitalization—two hundred dollars ($200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

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

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

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

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

PROPOSED RESCISSION

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 300 Plan will not be offered after December 31, 2018.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Rescinded: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED RESCISSION

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 600 Plan will not be offered after December 31, 2018.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Rescinded: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (3), (6), (8), (10), (11), (12), (13), (17), (18), (19), and (20); and removing section (18).

PURPOSE: This amendment revises the HSA Plan deductible, out-of-pocket maximum and clarifies influenza vaccinations, diabetes self-management education/training, family deductible, access to payment information, deductible and out-of-pocket accumulations, maximum

plan payments, HSA Plan eligibility, and Health Savings Account contributions when both spouses are state employees.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, benefit provisions, and covered charges of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars ($1,650); family, three thousand three hundred dollars ($3,300) and for non-network: per individual, *[four thousand dollars ($4,000)]* **three thousand three hundred dollars ($3,300)**; family, *[eight thousand dollars ($8,000)]* **six thousand six hundred dollars ($6,600)**.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—*[three thousand three hundred dollars ($3,300)]* **four thousand nine hundred fifty dollars ($4,950)**;

2. Network out-of-pocket maximum for family—*[six thousand six hundred dollars ($6,600);]* **nine thousand nine hundred dollars ($9,900). Any individual family member need only incur a maximum of seven thousand nine hundred dollars ($7,900) before the plan begins paying one hundred percent (100%) of covered charges for that individual;**

3. Non-network out-of-pocket maximum for individual—*[five thousand dollars ($5,000)]* **nine thousand nine hundred dollars ($9,900)**; and

4. Non-network out-of-pocket maximum for family—*[ten thousand dollars ($10,000)]* **nineteen thousand eight hundred dollars ($19,800)**.

(6) Influenza *[immunizations]* **vaccinations** provided by a non-network provider will be reimbursed up to twenty-five dollars ($25) once the member submits a receipt and a reimbursement form to the claims administrator.

(8) Four (4) diabetes **self-management** education/**training** visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

(10) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor **and pharmacy benefit manager** system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(11) Each subscriber will have access to payment information of the family unit **only when authorization is granted by the adult covered dependent(s)**.

(12) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes **non-Medicare** medical plans or continues enrollment under another subscriber's **non-Medicare medical** plan within the same plan year.

(13) *[Usual, customary, and reasonable fee allowed]* **Maximum plan payment**—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at *[the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor]* **one hundred ten percent (110%) of Medicare reimbursement**. Members may be held liable for the amount of the fee above the allowed amount.

(17) A**n active employee** subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section *[(20)]* **(19)** of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

[(18) If a retiree subscriber and/or his/her dependent(s) becomes eligible for Medicare in the upcoming plan year then s/he may not enroll in the HSA Plan during open enrollment.]

*[(19)]***(18)** If a**n active employee** subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber and/or his/her dependent(s) will be enrolled in the PPO *[600]* **1250** Plan. The subscriber may enroll in a different non-HSA Plan within thirty-one (31) days of notice from MCHCP.

*[(20)]***(19)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;
(B) Accident insurance;
(C) Disability insurance;
(D) Dental insurance;
(E) Vision insurance; or
(F) Long-term care insurance.

*[(21)]***(20)** Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both *[a husband and wife]* **spouses** are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars ($600) regardless of the number of HSAs or the number of children covered under the HSA

Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar ($300) contribution to each spouse to total maximum six hundred dollars ($600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

Deposit	Subscriber Only	All other coverage levels
January	$300.00	$600.00
April (delayed contribution due to health care FSA grace period)	$300.00	$600.00
All others	A proration of $300	A proration of $600

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

PURPOSE: This amendment revises the names of the medical plans and clarifies the following benefits: dental care, diabetes education, dialysis, genetic counseling, infusions, injections, nutrition counseling, and preventive services; alphabetizes the list of medical benefits; and renumbers as necessary.

(1) Benefit Provisions Applicable to the PPO *[300]* **750** Plan, PPO *[600]* **1250** Plan, and Health Savings Account (HSA) Plan. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(3) Covered Charges Applicable to the PPO *[300]* **750** Plan, PPO *[600]* **1250**, and HSA Plan.

(E) Plan benefits for the PPO *[300]* **750** Plan, PPO *[600]* **1250**, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;
(II) Hymenoptera venom (stinging insects);
(III) Inhalants; or
(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or
(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or
(II) Drugs when all of the following are met:
(a) History of allergy to a particular drug;
(b) There is no effective alternative drug; and
(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
(II) Food allergy;
(III) Hymenoptera venom allergy (stinging insects);
(IV) Inhalant allergy; or
(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular

dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

***[5.]*6.** Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed

arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

*[6.]***7.** Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

[7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;]

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific

standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease**. Treatment must be initiated within sixty (60) days of accident**; and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes **self-management training/***[E]*education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

15. Dialysis is covered when received through a network provider;

***[15.]*16.** Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

***[16.]*17.** Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

***[17.]*18.** Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

***[18.]*19.** Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

*[19.]***20.** Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azo**o**spermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

*[20.]***21.** Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain*[;]***.**

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

*[21.]***22.** Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

*[22.]***23.** Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

*[23.]***24.** Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars ($1,000).

(II) Programmable: two thousand dollars ($2,000).

(III) Digital: two thousand five hundred dollars ($2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

*[24.]***25.** Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

*[25.]***26.** Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs**,** or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

*[26.]***27.** Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

*[27.]***28.** Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual (DSM)*. If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

*[28.]***30.** Injections *[and infusions. Injections and infusions are covered]*. See preventive services for coverage of *[immunizations]* **vaccinations**. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered*[, including injectables,]* are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;
(XVIII) Postgastric surgery syndromes;
(XIX) Other prophylactic chemo-therapy;
(XX) Intestinal bypass or anastomosis status;
(XXI) Acquired absence of stomach;
(XXII) Pancreatic insufficiency; and
(XXIII) Ideopathic progressive polyneuropathy;

*[29.]***31.** Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

*[30.]***32.** Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

*[31.]***33.** Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

*[32.]***34.** Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

*[33.]***35.** Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

*[34.]***36.** Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

*[35.]***37.** Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

*[36.]***38.** Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered

if the following criteria are met:

I. Passive range of motion test was measured with agoniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with

diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

*[37.]***39.** Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. *[Immunizations]* **Vaccinations** recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, *[including X-rays and lab services,]* they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. *[Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older]* **Online weight management program offered through the plan's exclusive provider arrangement**;

*[38.]***40.** Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

*[39.]***41.** Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

*[40.]***42.** Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

*[41.]***43.** Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

*[42.]***44.** Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language

and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

*[43.]***45.** Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar ($10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

*[44.]***46.** Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

*[45.]***47.** Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED RESCISSION

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations. This rule established the policy of the board of trustees in regard to the PPO 300 Plan, PPO 600 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 300 and PPO 600 Plans will not be offered after December 31, 2018.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Rescinded: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED RULE

22 CSR 10-2.061 Plan Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055 or 22 CSR 10-2.090.

(A) Abortion—unless the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(B) Acts of war including—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(C) Alternative therapies—that are outside conventional medicine including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

(D) Assistive listening device.

(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.

(F) Athletic enhancement services and sports performance training.

(G) Autopsy.

(H) Birthing center.

(I) Blood donor expenses.

(J) Blood pressure cuffs/monitors.

(K) Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

(M) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(N) Childbirth classes.

(O) Comfort and convenience items.

(P) Cosmetic procedures.

(Q) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

(R) Dental care, including oral surgery.

(S) Devices or supplies bundled as part of a service are not separately covered.

(T) Dialysis received through a non-network provider.

(U) Educational or psychological testing unless part of a treatment program for covered services.

(V) Examinations requested by a third party.

(W) Exercise equipment.

(X) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

(Y) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(Z) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(AA) Health and athletic club membership—including costs of enrollment.

(BB) Hearing aid replacement batteries.

(CC) Home births.

(DD) Infertility treatment beyond the covered services to diagnose the condition.

(EE) Infusions received through a non-network provider.

(FF) Level of care, greater than is needed for the treatment of the illness or injury.

(GG) Long-term care.

(HH) Maxillofacial surgery.

(II) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

(JJ) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(KK) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

(LL) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(MM) Nocturnal enuresis alarm.

(NN) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

(OO) Non-medically necessary services.

(PP) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(QQ) Non-reusable disposable supplies.

(RR) Online weight management programs.

(SS) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

(TT) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

(UU) Physical and recreational fitness.

(VV) Private-duty nursing.

(WW) Routine foot care without the presence of systemic disease that affects lower extremities.

(XX) Services obtained at a government facility if care is provided without charge.

(YY) Sex therapy.

(ZZ) Surrogacy—pregnancy coverage is limited to plan member.

(AAA) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

(CCC) Travel expenses.

(DDD) Vaccinations requested by third party.

(EEE) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (5), and (6).

PURPOSE: This amendment revises the names of the medical plans and clarifies general appeal provisions, the appeals process for Medicare members, and documentation requirements when submitting an appeal to add dependents.

(1) Claims Submissions and Initial Benefit Determinations *[for Medical and Non-Medicare Primary Pharmacy Services]* **PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members**.

(2) General Appeal Provisions *[for Medical and Non-Medicare Primary Pharmacy Services]*.

(3) Appeal Process for Medical and Pharmacy Determinations **for PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members**.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. **Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s).** Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn or the newborn of an enrolled dependent retroactively to the date of birth if the appeal is received within three (3) months of the child's birth date*[. Valid proof of eligibility must be included with the appeal]*;

(6) Medicare *[Primary Pharmacy]* Appeals.

(B) Appeals rights and procedures for benefits covered by the Medicare Advantage Plan are provided as regulated by the Centers for Medicare and Medicaid Services. Members may contact the Medicare Advantage Plan for additional rights and procedures.

(C) Administrative Appeals as specified in subsection (3)(B) of this rule shall follow the procedures set forth in that subsection.

*AUTHORITY: section 103.059, RSMo [2000] **2016**. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.080 Miscellaneous Provisions. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment revises the names of the medical plans.

(5) The PPO *[300]* **750** Plan, PPO *[600]* **1250** Plan, and Health Savings Account Plan benefits including pharmacy are self-funded by the plan. MCHCP has subrogation rights under section 376.433, RSMo for any amounts expended for these benefits.

*AUTHORITY: section 103.059, RSMo [2000] **2016**. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in

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

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

PROPOSED RULE

22 CSR 10-2.088 Medicare Advantage Plan for Non-Active Medicare Primary Members

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medicare Advantage Plan for Non-active Medicare-primary members of the Missouri Consolidated Health Care Plan.

(1) The medical benefit for non-Active Medicare primary members is provided through a fully-insured Group Medicare Advantage PPO Plan as regulated by the Centers for Medicare and Medicaid Services (CMS) herein after referred to as the Medicare Advantage Plan. For purposes of this rule non-Active Medicare primary members include: Medicare-eligible members who are eligible retirees, terminated vested subscribers, long-term disability subscribers, and their eligible dependents who have Medicare.

(A) Members must be enrolled in Medicare Parts A and B to be eligible for the Medicare Advantage Plan.

(B) Non-active subscribers that have Medicare and/or their dependents that have Medicare shall receive their medical benefit through the Medicare Advantage Plan.

(C) Subscribers enrolled in the Medicare Advantage Plan will choose another medical plan offered by MCHCP for their non-Medicare dependents.

(D) Beginning the first day of the month in which a non-active Medicare primary member turns sixty-five (65) years old, they shall be transferred to the Medicare Advantage Plan.

(E) A member who opts out of the Medicare Advantage Plan will lose MCHCP eligibility and will not be allowed to enroll in a medical plan at a later date unless otherwise provided for in these rules.

(2) The Medicare Advantage Plan design is defined by the vendor, including deductible, out-of-pocket maximum, and benefits covered. Benefits shall be substantially similar to the benefits offered to non-Medicare members.

(3) The Medicare Advantage Plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-2.020, and in conjunction with the rules set forth by CMS.

(4) Appeals.

(A) Appeals concerning claims and benefits are managed by the vendor in accordance with CMS rules.

(B) Administrative appeals concerning eligibility and termination are managed by MCHCP in accordance with 22 CSR 10-2.075.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment clarifies eligibility for the Pharmacy Employer Group Waiver Plan, the Part B drug benefit, and preventive drugs; updates the Medicare Part D coverage stage and the copayment amounts; and removes language regarding the Medicare Prescription Drug Only Plan.

(1) The pharmacy benefit for Medicare primary **non-active** members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(A) *[The following Medicare primary members]* **Non-active subscribers that have Medicare primary coverage and their dependents that have Medicare primary coverage** enrolled in *[the PPO 300, PPO 600, or]* the Medicare *[Prescription Drug Only]* **Advantage** Plan shall receive their pharmacy benefit through the Medicare Prescription Drug Plan*[:]***.**

[1. Active employee members that have Medicare primary coverage and their dependents that have Medicare primary coverage; and

2. Retiree members that have Medicare primary coverage and their dependents that have Medicare primary coverage.]

(B) The non-Medicare *[primary]* dependents of Medicare primary *[members]* **non-active subscribers** will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non–Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[three thousand seven hundred fifty dollars ($3,750)]* **three thousand eight hundred twenty dollars ($3,820)**, the member will pay the following copayments:

A. Preferred Formulary Generic Drugs: thirty-one- (31-) day supply has *[an eight dollar ($8)]* **a ten dollar ($10)** copayment; sixty- (60-) day supply has a *[sixteen dollar ($16)]* **twenty dollar ($20)** copayment; ninety- (90-) day supply at retail has a *[twenty-four dollar ($24)]* **thirty dollar ($30)** copayment; and a ninety- (90-) day supply through home delivery has a *[twenty dollar ($20)]* **twenty-five dollar ($25)** copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a *[thirty-five dollar ($35)]* **forty dollar ($40)** copayment; sixty- (60-) day supply has *[a seventy dollar ($70)]* **an eighty ($80) dollar** copayment; ninety- (90-) day supply at retail has *a [one hundred five dollar ($105)]* **one hundred twenty ($120) dollar** copayment; and a ninety- (90-) day supply through home delivery has *[an eighty-seven dollar and fifty cent ($87.50)]* **a one hundred ($100) dollar** copayment; and

C. Non-preferred Formulary Drugs and approved excluded drugs: thirty-one- (31-) day supply has a one hundred dollar ($100) copayment; sixty- (60-) day supply has a two hundred dollar ($200) copayment; ninety- (90-) day supply at retail has a three hundred dollar ($300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar ($250) copayment;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand seven hundred fifty dollars ($3,750)]* **three thousand eight hundred twenty dollars ($3,820**) and remain below *[five thousand dollars ($5,000)]* **five thousand one hundred dollars ($5,100)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars ($5,000)]* **five thousand one hundred dollars ($5,100)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars ($5,000)]* **five thousand one hundred dollars ($5,100)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[three dollar and thirty-five cent ($3.35)]* **three dollar and forty cent ($3.40)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or an *[eight dollar and thirty-five cent ($8.35)]* **eight dollar and fifty cent ($8.50)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage; **and**

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs*[; and]***.**

[6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.]

(H) Medicare Part B Prescription Drugs **are excluded from the Medicare Prescription Drug Plan**. *[For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to a Medicare Part B contracted retail pharmacy which is in the pharmacy benefit manager (PBM) network. Medicare Part B prescriptions include, but are not limited to, the following:]*

[1. Diabetes testing and maintenance supplies;

2. Respiratory agents;

3. Immunosuppressants; and

4. Oral anti-cancer medications.]

(I) Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[1. Prescribed Vitamin D for all ages:

A. The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D_2 or D_3 per dose;

2. Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]

*[3.]***1.** *[Influenza v]***V**accines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

*[4.]***2.** Preferred formulary brand contraception and non-preferred contraception when the provider determines a generic is not medically appropriate or a generic version is not available.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending the purpose and section (1).

PURPOSE: This amendment revises the names of the medical plans, copayments, preventive drugs, and out-of-pocket maximum.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the [PPO 300, PPO 600] ***PPO 750 Plan, PPO 1250 Plan****, and Health Savings Account Plan of the Missouri Consolidated Health Care Plan.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO *[300]* **750 Plan** and PPO *[600]* **1250 Plan**.

1. Network:

A. Preferred formulary generic drug copayment: *[Eight dollars ($8)]* **Ten Dollars ($10)** for up to a thirty-one- (31-) day supply; *[sixteen dollars ($16)]* **twenty dollars ($20)** for up to a sixty- (60-) day supply; and *[twenty-four dollars ($24)]* **thirty dollars ($30)** for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Preferred formulary brand drug copayment: *[Thirty-five dollars ($35)]* **Forty dollars ($40)** for up to a thirty-one- (31-) day supply; *[seventy dollars ($70)]* **eighty dollars ($80)** for up to a sixty- (60-) day supply; and *[one hundred and five dollars ($105)]* **one hundred twenty dollars ($120)** for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars ($100) for up to a thirty-one- (31-)

day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Specialty drug copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

*[D.]***E.** Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

*[E.]***F.** Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: *[Eight dollars ($8)]* **Ten dollars ($10)** for up to a thirty-one- (31-) day supply; *[sixteen dollars ($16)]* **twenty dollars ($20)** for up to a sixty- (60-) day supply; and *[twenty dollars ($20)]* **twenty-five dollars ($25)** for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: *[Thirty-five dollars ($35)]* **Forty dollars ($40)** for up to a thirty-one- (31-) day supply; *[seventy dollars ($70)]* **eighty dollars ($80)** for up to a sixty- (60-) day supply; and *[eighty-seven dollars and fifty cents ($87.50)]* **one hundred dollars ($100)** for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) Specialty drug copayment: Seventy-five dollars ($75) for up to a thirty-one- (31-) day supply; one hundred fifty ($150) for up to sixty (60-) day supply; and two hundred twenty-five ($225) for up to ninety- (90-) day supply for a specialty drug on the formulary;

*[F.]***G.** Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

*[G.]***H.** Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

*[H.]***I.** The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

*[I.]***J.** If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

*[J.]***K.** If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum;

L. Preferred select brand drugs, as determined by the PBM: Ten dollars ($10) for up to a thirty-one- (31-) day supply; twenty dollars ($20) for up to a sixty- (60-) day supply; and twenty-five dollars ($25) for up to a ninety- (90-) day supply; and

*[K.]***M.** Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]

*[(III)]***(I)** *[Influenza v]***V**accine *[and administration as]* recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

*[(IV)]***(II)** Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

*[(V)]***(III)** Prescribed preferred diabetic test strips and lancets; and

*[(VI)]***(IV)** One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. **Network** *[I]***i**ndividual—*[five thousand one hundred dollars ($5,100)]* **four thousand one hundred fifty dollars ($4,150)**.

D. **Network** *[F]***f**amily—*[ten thousand two hundred dollars ($10,200)]* **eight thousand three hundred dollars ($8,300)**.

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. Preferred formulary generic drug: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: Twenty percent (20%)

coinsurance after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met;

E. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]

*[(III)]***(I)** *[Influenza v]***V**accine**s** and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

*[(IV)]***(II)** Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer;

H. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), and (5).

PURPOSE: This amendment revises foster parent eligibility requirements, enrollment procedures, enrollment of a newborn child proof of eligibility procedures, and disabled dependent documentation timeframes.

(2) Eligibility Requirements.

(B) Dependent Coverage. Eligible dependents include:

1. Spouse. If both spouses are eligible foster parents, each spouse must enroll separately;

2. Children.

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

(I) Natural child of subscriber or spouse;

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

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

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

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

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

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

(VIII) *[Newborn]* **Child** of a dependent *[or]* **as long as the parent is a dependent on the newborn's date of birth. The dependent and the child of the dependent must remain continuously covered on the plan for the child of the dependent to remain eligible;**

(IX) *[c]***C**hild of a dependent when paternity by the dependent is established after birth *[so]* **as** long as the parent is a dependent on *[the newborn's day of birth or]* the date the child's paternity was established *[and continues to be covered as a dependent of the subscriber]* **The dependent and the child of the dependent must remain continuously covered on the plan for the child of the dependent to remain eligible**; or

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

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

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

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

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

(3) Enrollment Procedures.

(C) An eligible foster parent may *[apply for]* **elect or change** coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

1. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the eligible foster parent's responsibility to notify MCHCP of the life event;

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

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

A. Employer-sponsored medical, dental, or vision plan terminates;

B. Eligibility for employer-sponsored coverage ends;

C. Employer contributions toward the premiums end; or

D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

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

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

5. Default Enrollment

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

*[6.]***B.** If an eligible foster parent is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the HSA Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year;

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

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

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not

received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

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

(E) Disabled Dependent.

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

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

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

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

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

AUTHORITY: sections 103.059 and 103.078, RSMo 2016. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

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

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

PROPOSED AMENDMENT

22 CSR 10-2.140 Strive for Wellness® Health Center Provisions, Charges, and Services. The Missouri Consolidated Health Care Plan is amending sections (2) and (4).

PURPOSE: This amendment clarifies available services and preventive services; and revises the names of the medical plans.

(2) Available Services. The health center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:

(I) *[Immunizations]* **Vaccinations** including *[immunization for]* influenza **vaccine**;

(O) Ordinary and routine care of the nature of a visit to the *[doctor's]* **health care provider's** office; and

(4) Charges for the following services apply:

(A) Office visit—

1. For active employees enrolled in the MCHCP PPO *[300]* **750** or PPO *[600]* **1250** Plan, fifteen dollars ($15) payable at the time of service;

2. For active employees enrolled in the Health Savings Account (HSA) Plan forty-five dollars ($45) payable at the time of service; and

3. The office visit includes the evaluation and management of the patient and any associated laboratory services performed by the health center;

(B) Preventive *[care]* **services**—

1. For active employees enrolled in the MCHCP PPO *[300]* **750** Plan, PPO *[600]* **1250** Plan, or HSA Plan, preventive *[care is]* **services are** covered at one hundred percent (100%); and

2. Preventive *[care]* **services** shall have the same meaning as in 22 CSR 10-2.055; and

(C) Health center services are outside the MCHCP PPO *[300]* **750** Plan, PPO *[600]* **1250** Plan, and HSA Plan benefits and payments for health center services do not apply toward any associated deductible or out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo [2000] ***2016****. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. Amended: Filed Oct. 29, 2014, effective May 30, 2015. Amended: Filed Oct. 28, 2015, effective May 30, 2016. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

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

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

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