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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN
SECRETARY OF STATE

MISSOURI REGISTER

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The rules are codified in the *Code of State Regulations* in this system—

Title	*Code of State Regulations*	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 13—Service and Billing Practices for Residential Customers of Electric, Gas and Water Utilities

EMERGENCY AMENDMENT

4 CSR 240-13.055 Cold Weather Maintenance of Service: Provision of Residential Heat-Related Utility Service During Cold Weather. The commission is adding section (14).

PURPOSE: This amendment provides additional repayment plans for residential users of natural gas for heating purposes.

*EMERGENCY STATEMENT: The price of natural gas has risen sharply throughout the fall to a new high level, requiring many households to spend a much higher percentage of their overall budgets on home heating than in previous winters. This amendment offers options for level payments throughout the year and lessens the financial requirements for those customers disconnected for non-payment to be reconnected to a natural gas supply. As the heating season progresses, without this emergency relief, some customers will not be able to pay their bills in a timely manner, which may result in termination of heating service to their homes. This emergency amendment is necessary to protect the public safety, health and welfare, as without home heating during the winter months, people will suffer and may die. The Public Service Commission has conducted an expedited proceeding, including notice and the receipt of comments and convening a public hearing to take testimony and hear comments. This emergency amendment includes a mechanism whereby natural gas utilities subject to this amendment shall be able to recover all of the reasonably-incurred costs of complying with this amendment. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the procedural and substantive protections extended in the **Missouri** and **United States Constitutions**. The Public Service Commission believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed December 16, 2005, effective December 26, 2005, expires March 31, 2006.*

(14) Special Provisions for the 2005–2006 Heating Season. This amendment only applies to providers of natural gas services to residential customers. Other providers of heat-related utility services will continue to provide such service under the terms of sections (1) through (13) of this rule. The provisions of sections (1) through (13) of this rule continue to apply to providers of natural gas service except where inconsistent with the terms of this section.

(A) From January 1, 2006 through March 31, 2006, notwithstanding paragraph (10)(C)2. of this rule to the contrary, a gas utility shall restore service upon initial payment of fifty percent (50%) or five hundred dollars ($500) whichever is lesser, of the preexisting arrears, with the deferred balance to be paid as provided in subsection (10)(B). Any reconnection fee, trip fee, collection fee or other fee related to reconnection, disconnection or collection shall also be deferred. Between January 1, 2006 and April 1, 2006, any customer threatened with disconnection may retain service by entering into a payment plan as described in this subsection. Any payment plan entered into under this emergency amendment shall remain in effect (as long as its terms are adhered to) for the term of the payment plan even after the effective period of this amendment has expired. However, a gas utility shall not be required to offer reconnection or retention of service under this subsection (14)(A) more than once for any customer.

(B) Any customer who is not disconnected or in receipt of a disconnect notice shall, at the customer's request, be permitted to enroll immediately in a gas utility's equal payment, budget-billing or similar plan. Any current bill or existing arrearage at the time of enrollment shall be dealt with consistent with paragraphs (10)(B)1. through 4. of this rule, provided that the customer agrees to make the initial payment prescribed in paragraph (10)(C)1. or subsection (14)(A) as applicable.

(C) If a customer enters into a cold weather rule payment plan under this rule:

1. Late payment charges shall not be assessed except with respect to failure to make timely payments under the payment plan; and

2. The gas utility shall not charge customers interest on the account balance for any deferral period.

(D) Any customer who enters into a cold weather rule payment agreement during the time this emergency rule is in effect and fully complies with the terms of the payment plan shall be treated, going forward, as not having defaulted on any cold weather rule payment agreement.

(E) A gas utility shall describe the provisions of section (14) in any notices or contacts with customers. In telephone contacts with customers expressing difficulty paying their gas bills, gas utilities shall inform those customers of their options under section (14).

(F) A gas utility shall be permitted to recover the costs of complying with this rule as follows:

1. The cost of compliance with this rule shall include any reasonable costs incurred to comply with the notice requirements of this rule;

2. The cost of compliance with this rule shall not include any lost revenues or other costs associated with the gas utility's agreement to temporarily waive or suspend reconnection fees or deposit requirements otherwise applicable to customers who were qualified for financial assistance under the Low-Income Heating Energy Assistance Program and who applied for or received such assistance during the winter of 2005 through March 31, 2006;

3. No gas utility shall be permitted to recover costs under this subsection that would have been incurred in the absence of this emergency amendment; and

4. Any net cost resulting from this rule as of June 30, 2007 shall accumulate interest at the utility's short-term borrowing rate until such times as it is recovered in rates.

(G) A gas utility shall be permitted to recover the costs of complying with this rule through an Accounting Authority Order:

1. The commission shall grant an Accounting Authority Order, as defined below, upon application of a gas utility, and the gas utility may book to Account 186 for review, audit and recovery all incremental expenses incurred and incremental revenues that are caused by this emergency amendment. Any such Accounting Authority Order shall be effective until September 30, 2007.

2. The commission has adopted the Uniform System of Accounts in 4 CSR 240-4.040. Accounting Authority Orders are commission orders that allow a utility to defer certain expenses to Account 186 under the Uniform System of Accounts for possible recovery later. *State ex rel. Office of the Public Counsel v. Public Service Commission*, 858 SW2d 806 (Mo. App. 1993); *Missouri Gas Energy v. Public Service Commission*, 978 SW2d 434 (Mo. App. 1998).

(H) This section shall be in effect through March 31, 2006.

*AUTHORITY: sections 386.250 and 393.140, RSMo 2000 and 393.130, RSMo Supp. [2003] **2004**. Original rule filed June 13, 1984, effective Nov. 15, 1984. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 16, 2005, effective Dec. 26, 2005, expires March 31, 2006.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 40—Land Reclamation Commission
Chapter 7—Bond and Insurance Requirements for Surface Coal Mining and Reclamation Operations

EMERGENCY AMENDMENT

10 CSR 40-7.011 Bond Requirements. The commission is amending sections (1)–(7) of this rule.

PURPOSE: This rule will change the bond requirements for surface coal mining operations from a bond "pool" to "full cost" bonding. This rule also clarifies what types of bonds are acceptable and establishes the specific requirements for each.

EMERGENCY STATEMENT: This emergency amendment changes the current state bonding requirements for surface coal mining operations from that of a bond "pool" to "full cost" bonding. It also describes which types of bonds are acceptable to be filed with the director of the Land Reclamation Program and their specific requirements in order to be deemed acceptable. This emergency amendment is necessary because of a compelling governmental interest. Without this amendment the existing coal industry will be required to waste significant amounts of money and resources in order to comply with current rules only to change again when full cost bonding becomes effective later on in 2006 as described below. Additionally, federal monies will be lost that would otherwise be used to protect the public's safety and general welfare in the vicinity of old, abandoned coal mines as further described below. Therefore, this amendment is seen to be necessary in that it will provide for a seamless transition for the existing coal mining industry from the current federal regulation of this industry to one of state regulation. This transition from federal to state control is expected to take effect during January, 2006.

Federal regulation requires full cost bonding which the coal industry is currently seeking to comply with. In fact all but one coal permit is adequately covered for full cost bonding. If this rule is not enacted as an emergency measure the industry would be mandated to comply with the current "bond pool" state regulation. This would require a complete replacement of most industry bonds in force at the present time. This would be burdensome on this industry in that the cost of replacing bonds and the time involved in doing so would be a significant financial impact on these businesses. To further this explanation, an additional burden would be realized by the coal mining industry when the normal, proposed rulemaking for this amendment becomes effective during the summer of 2006. After replacing all bonds to comply with existing "bond pool" state regulation, the industry would once again be required to replace all bonds to comply with the "full cost" bonding provisions of this amendment. Rather than put the industry through such a scenario of replacing bonds in January then replacing them again in August only to arrive at the same point they presently are, it seems justifiable to request that this emergency rulemaking become effective to keep the current federally mandated bonding requirements stable and uninterrupted in order to minimize the effects on the industry this amendment is designed to address.

Also, this emergency amendment is seen to be necessary in order to provide for protection of the public's health, safety, and general welfare. In order for the state to acquire primacy in the regulation of the coal mining industry from the federal government, including the administration and the receipt of federal monies for the implementation of the abandoned mined land program, this emergency amendment to the existing rules must first be in place. The abandoned mined land program is a program where very old, pre-law coal mine sites are reclaimed by the state with monies provided by federal grant. Oftentimes, abandoned coal mined lands pose serious safety threats to the general public and, at times, health problems may also be realized in and around areas of past coal mining where no reclamation was ever required. If this emergency amendment is not placed into effect in January 2006, the federal grant monies will not be available to the State of Missouri in order to address the remediation of sites that pose a health and/or a safety issue for those citizens living in or around old, abandoned surface coal mines. These citizens are then left with no recourse other than to live with these imminent dangers to their health and/or safety other than to provide for remediation out of their own pockets. This is generally well beyond the financial reach of most ordinary citizens of the state.

*A proposed amendment which covers this same material was published in the January 3, 2006 issue of the **Missouri Register** (31 MoReg 28–32). The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Land Reclamation Commission believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed on December 21, 2005, effective January 1, 2006, expires June 29, 2006.*

(1) Definitions.

(C) Personal bond means an *[undertaking by the permittee to successfully complete reclamation according to commission regulations,]* **indemnity agreement in a sum certain executed by the permittee as principal which is** supported by negotiable certificates of deposit or irrevocable letters of credit which may be drawn upon by the *[commission]* **director** if reclamation is not completed or if the permit is revoked prior to completion of reclamation.

(D) Phase I bond means a performance bond conditioned on the release of *[eighty percent (80%)]* **sixty percent (60%)** of the bond

upon the successful completion of Phase I reclamation of a permit area in accordance with the approved reclamation plan**.** *[, with the rest of the bond remaining in effect until Phase III liability is released.]*

(2) Requirement to File a Bond.

(A) After an application for a permit to conduct surface coal mining and reclamation operations has been approved under 10 CSR 40-6, but before the permit is issued, the applicant shall file with the director a performance bond payable to the *[s]*State **of Missouri**. The performance bond shall be conditioned upon the faithful performance of all the requirements of the Surface Coal Mining Law, the regulatory program, the permit and the reclamation plan, and bonded liability shall continue until reclamation is completed and approved by the *[commission]* **director**. In the event of forfeiture, the amount remaining on the bond may be used to complete reclamation in any location in the permit area.

(B) The applicant shall file, with the approval of the director, a bond or bonds under one of the following schemes to cover the bond amounts for the permit area as determined in accordance with 10 CSR 40-7.011(4):

1. A performance bond or bonds for the entire permit area;

2. A cumulative bond schedule and the performance bond required for full reclamation of the initial area to be disturbed; or

3. An incremental bond schedule and the performance bond required for the first increment in the schedule.

(3) Incremental Bonding.

(C) Independent increments shall be of sufficient size and configuration to provide for efficient reclamation operations should reclamation by the *[regulatory authority]* **director** become necessary pursuant to 10 CSR 40-7.031(3).

(4) Bond Amounts.

[(A) Except as noted in subsection (4)(B), the amount of Phase I bonds shall be calculated at two thousand five hundred dollars ($2,500) per every bonded acre unless the area is a coal preparation area in which Phase I bond shall be calculated at ten thousand dollars ($10,000) per acre.

(B) For mines with fewer than one thousand (1,000) bonded acres, the minimum amount of Phase I bond applied to a single permit shall be ten thousand dollars ($10,000), or the equivalent of twenty (20) acres of bond for each acre of open pit area, whichever is greater.]

(A) The amount of the bond required for each bonded area shall:

1. Be determined by the director;

2. Depend upon the requirements of the approved permit and reclamation plan;

3. Reflect the probable difficulty of reclamation, giving consideration to such factors as topography, geology, hydrology, and revegetation potential; and

4. Be based on, but not limited to, the estimated cost submitted by the permit applicant.

(B) The amount of the bond shall be sufficient to assure the completion of the reclamation plan if the work has to be performed by the director in the event of forfeiture, and in no case shall the total bond initially posted for the entire area under one (1) permit be less than ten thousand dollars ($10,000).

(5) Changing Bond Amounts.

[(A) The Phase I bond amount listed in subsection (4)(A) of this rule may be adjusted annually by a maximum of two hundred fifty dollars ($250) per acre, not to exceed a maximum per acre bond amount of five thousand dollars ($5,000) per acre.

(B) The Phase I bond amount listed in subsection (4)(B) of this rule for coal preparation areas may be adjusted annually by a maximum of five hundred dollars ($500) per acre, not to exceed a maximum per acre bond amount of fifteen thousand dollars ($15,000) per acre.

(C) The changes allowed in subsection (5)(A) and (B) shall be proposed by the commission through the normal rulemaking process after demonstration by the director that such action is necessary to ensure adequate bonding amounts.

(D) The director shall calculate the liability to the Coal Mine Land Reclamation Fund on an annual basis and shall on the basis of the calculations determine whether to pursue rulemaking to raise the bonding amounts listed in subsections (4)(A) and (B) of this rule.

(E) The calculations of the minimum Phase I reclamation bond amount for subsections (4)(A) and (B) shall depend upon the reclamation requirements of the approved permits, and shall reflect the probable difficulty of reclamation giving consideration to such factors on-site topography, geology, hydrology, and revegetation potential.]

(A) The amount of the bond required and the terms of the acceptance of the applicant's bond shall be adjusted by the director from time-to-time as the area requiring bond coverage is increased or decreased or where the cost of future reclamation changes. The director may specify periodic times or set a schedule for reevaluating and adjusting the bond amount to fulfill this requirement.

(B) The director shall—

1. Notify the permittee and the surety, bank, savings and loan company, or third-party guarantor of any proposed adjustment to the bond amount; and

2. Provide the permittee an opportunity for an informal conference on the adjustment.

(C) A permittee may request reduction of the amount of the performance bond upon submission of evidence to the director proving that the permittee's method of operation or other circumstances reduces the estimated cost for the regulatory authority to reclaim the bonded area. Bond adjustments which involve undisturbed land or revision of the cost estimate of reclamation are not considered bond releases subject to the procedures of 10 CSR 40-7.021(3).

(D) In the event that an approved permit is revised in accordance with 10 CSR 40-6.090(4), the director shall review the bond for adequacy and, if necessary, shall require adjustment of the bond to conform to the permit as revised.

(6) Types of Bonds. The director may accept surety bonds, personal bonds and self-bonding.

(A) Surety bonds shall be subject to the following conditions:

1. The surety bond shall be submitted on a form provided by the director;

2. No bond of a surety company will be accepted unless the bond shall not be cancelable for any reason whatsoever, including, but not limited to, nonpayment of premium, bankruptcy or insolvency of the permittee or issuance of notices of violations or cessation orders and assessment of penalties with respect to the operations covered by the bond, except that surety bond coverage for lands not disturbed may be canceled if the surety provides written notification and the director is in agreement. The director shall advise the surety, within thirty (30) days after receipt of a notice to cancel bond, whether the bond may be canceled on an undisturbed area;

3. A surety company's bond shall not be accepted in excess of ten percent (10%) of the surety company's capital surplus account as shown on a balance sheet certified by a certified public accountant;

4. The total amount of the bonds issued by a surety on behalf of any permittee shall not exceed thirty percent (30%) of the surety

company's capital surplus account as shown on a balance sheet certified by a certified public accountant;

5. The surety shall be licensed to conduct a surety business in Missouri;

6. Both the surety and the permittee shall be primarily liable for completion of *[pit]* reclamation, with the surety's liability being limited to the penalty amount of the bond;

7. The bond shall provide that—

A. The surety will give prompt notice to the permittee and the director of any notice received or action filed alleging the insolvency or bankruptcy of the surety or alleging any violations of regulatory requirements which could result in suspension or revocation of the surety's license to do business; and

B. In the event the surety becomes unable to fulfill its obligations under the bond for any reason, notice shall be given immediately to the permittee and the director;

8. The bond shall provide a mechanism for a *[bank or]* surety company to give prompt notice to the *[regulatory authority]* **director** and the permittee of any action filed alleging the insolvency or bankruptcy of the surety company*[, the bank]* or the permittee, or alleging any violations which would result in suspension or revocation of the surety *[or bank charter or]* license to do business. Upon the incapacity of a surety by reason of bankruptcy*[,]* **or** insolvency, or suspension or revocation of its license, the permittee shall be deemed to be without bond coverage in violation of subsection (2)(A) **and shall promptly notify the director**. The director**, upon notification of the surety's bankruptcy or insolvency, or suspension or revocation of its license,** shall issue a notice of violation against any operator who is without bond coverage. The notice shall specify a reasonable period to replace bond coverage, not to exceed *[sixty (60)]* **ninety (90)** days. During this period, the director or his/her authorized agent shall conduct weekly inspections to ensure continuing compliance with other permit requirements, the regulatory program and the law. The notice of violation, if abated within the period allowed, shall not be counted as a notice of violation for purposes of determining a pattern of willful violation under 10 CSR 40-7.031(1)*[(A)6.]***(F)2.** and need not be reported as a past violation in permit applications under 10 CSR 40-6.030(2) or 10 CSR 40-6.100(2). If a notice of violation is not abated in accordance with the schedule, a cessation order shall be issued requiring immediate compliance with 10 CSR 40-3.150(4). *[Mining operations shall not resume until the director has determined that an acceptable bond has been posted.]* The operator shall also immediately begin to conduct reclamation operations in accordance with the reclamation plan. **Mining operations shall not resume until the director has determined that an acceptable bond has been posted**; and

9. The bond shall be forfeitable upon revocation of the underlying permit.

(B) Personal bonds secured by certificates of deposit shall be subject to the following conditions:

1. The bonds shall be submitted on a form provided by the *[commission]* **director**;

2. The certificate(s) shall be in the amount of the bond or in an amount greater than the bond*[, subject to the limitations of paragraph (5)(B)4. of this rule,]* **and** shall be made payable to or assigned to **the State of** Missouri, both in writing and upon the records of the bank **or savings and loan company** issuing the certificates, and shall be automatically renewable at the end of the term of the certificate. If assigned, banks **and savings and loan companies** issuing the certificate(s) waive all rights of set off or liens against the certificate(s);

3. Interest on the certificate of deposit shall be paid to the permittee;

4. No single certificate of deposit shall exceed the sum of one hundred thousand dollars ($100,000) nor shall any permittee submit certificates of deposit aggregating more than one hundred thousand dollars ($100,000) **or the maximum insurable amount as determined by the Federal Deposit Insurance Corporation** from a single bank **or savings and loan company**. The issuing bank or savings and loan company must be insured by *[either]* the Federal Deposit Insurance Corporation *[or the Federal Savings and Loan Insurance Corporation]*;

5. The certificate of deposit shall be kept in the custody of **the State of** Missouri until the bond is released by the *[commission]* **director**;

6. The bank **or savings and loan company** issuing the certificate(s) of deposit for bonding purposes shall give prompt notice to the *[commission]* **director** and the permittee of any insolvency or bankruptcy of the bank **or savings and loan company**;

7. The bond shall provide a mechanism for a bank *[or surety company]* **or savings and loan company** to give prompt notice to the *[regulatory authority]* **director** and the permittee of any action filed alleging the insolvency or bankruptcy of the *[surety company, the]* bank**, savings and loan company** or the permittee, or alleging any violations which would result in suspension or revocation of the *[surety or]* bank **or savings and loan company** charter or license to do business. Upon *[notice]* **the incapacity** of any bank **or savings and loan company by reason of** insolvency or bankruptcy, **or suspension or revocation of its charter or license,** the permittee shall be deemed to be without bond coverage in violation of subsection (2)(A). The director**, upon notification of the bank's or savings and loan company's bankruptcy or insolvency, or suspension or revocation of its charter or license,** shall issue a notice of violation against any operator who is without bond coverage. The notice shall specify a reasonable period to replace **bond** coverage, not to exceed *[sixty (60)]* **ninety (90)** days. During this period, the director or his/her authorized agent shall conduct weekly inspections to ensure continuing compliance with other permit requirements, the regulatory program and the law. A notice of violation, if abated within the period allowed, shall not be counted as a notice of violation for purposes of determining a pattern of willful violation under 10 CSR 40-7.031(1)(F)2. and need not be reported as a past violation in permit applications under 10 CSR 40-6.030(2) or 10 CSR 40-6.100(2). If a notice of violation is not abated in accordance with the schedule, a cessation order shall be issued requiring immediate compliance with 10 CSR 40-3.150(4). The operator shall also immediately begin to conduct reclamation operations in accordance with the reclamation plan**. Mining operations shall not resume until the director has determined that an acceptable bond has been posted**; and

8. The bond shall be forfeitable upon revocation of the underlying permit.

(C) Personal bonds secured by letters of credit shall be subject to the following conditions:

1. The bond and the letters of credit shall be submitted on forms provided by the *[commission]* **director**;

2. The letter of credit shall be no less than the face amount of the bond and shall be irrevocable**. A letter of credit used as security in areas requiring continuous bond coverage shall be forfeited and shall be collected by the director if not replaced by other suitable bond or letter of credit at least thirty (30) days before its expiration date**;

3. The beneficiary of the letter of credit shall be the *[director of the]* **State of** Missouri *[Land Reclamation Commission]*;

4. The letter of credit shall be issued by a bank *[or trust company located]* **authorized to do business** in the United States. If the issuing bank *[or trust company]* is located in another state, a bank *[or trust company]* located in Missouri must confirm the letter of credit. Confirmations shall be irrevocable and on a form provided by the director;

5. The letter of credit shall be governed by Missouri law. The Uniform Customs and Practice for Documentary Credits, fixed by the International Chamber of Commerce, shall not apply;

6. The letter of credit shall provide that the director may draw upon the credit by making a demand for payment, accompanied by his/her statement that the commission has declared the permittee's bond forfeited;

7. The issuer of a letter of credit or confirmation shall warrant that the issuance will not constitute a violation of any statute or regulation which limits the amount of loans or other credits which can be extended to any single borrower or customer or which limits the aggregate amount of liabilities which the issuer may incur at any one (1) time from issuance of letters of credit and acceptances;

8. The bank issuing the letter(s) of credit for bonding purposes shall give prompt notice to the *[commission]* **director** and the permittee of any insolvency or bankruptcy of the bank;

9. **The bond shall provide a mechanism for a bank to give prompt notice to the director and the permittee of any action filed alleging the insolvency or bankruptcy of the bank or the permittee, or alleging any violations which would result in suspension or revocation of the bank's charter or license to do business.** Upon *[notice]* **the incapacity** of any bank **by reason of** insolvency or bankruptcy, **or suspension or revocation of its charter or license,** the permittee shall be deemed to be without bond coverage in violation of subsection (2)(A). The director**, upon notification of the bank's bankruptcy or insolvency, or suspension or revocation of its charter or license,** shall issue a notice of violation against any operator who is without bond coverage. The notice shall specify a reasonable period to replace bond coverage, not to exceed *[sixty (60)]* **ninety (90)** days. During this period, the director or his/her authorized agent shall conduct weekly inspections to ensure continuing compliance with other permit requirements, the regulatory program and the law. A notice of violation, if abated within the period allowed, shall not be counted as a notice of violation for purposes of determining a pattern of willful violation under 10 CSR 40-7.031(1)(F)2. and need not be reported as a past violation in permit applications under 10 CSR 40-6.030(2) or 10 CSR 40-6.100(2). If a notice of violation is not abated in accordance with the schedule, a cessation order shall be issued **requiring the immediate compliance with 10 CSR 40-3.150(4). The operator shall also immediately begin to conduct reclamation operations in accordance with the reclamation plan. Mining operations shall not resume until the director has determined that an acceptable bond has been posted**; and

10. The bond shall be forfeitable upon revocation of the underlying permit.

(D) Self-Bonding.

1. Definitions. For the purposes of this section only—

A. Current assets means cash or other assets or resources which are reasonably expected to be converted to cash or sold or consumed within one (1) year or within the normal operating cycle of the business;

B. Current liabilities means obligations which are reasonably expected to be paid or liquidated within one (1) year or within the normal operating cycle of the business;

C. Fixed assets means plant and equipment, but does not include land or coal in place;

D. Liabilities means obligations to transfer assets or provide services to other entities in the future as a result of past transactions;

E. Net worth means total assets minus total liabilities and is equivalent to owners' equity; *[and]*

F. Parent corporation means a corporation which owns or controls the applicant; and

[F.] **G.** Tangible net worth means net worth minus intangibles such as goodwill and rights to patents or royalties.

2. The *[commission]* **director** may accept a self-bond if the following conditions are met **by the applicant or its parent corporation guarantor**:

A. The applicant designates an agent for service of process in the state;

B. The applicant has been in continuous operation as a business entity the five (5) years **immediately** preceding the application. The *[commission]* **director** may accept the bond of a joint venture with fewer than five (5) years of continuous operation if each member has been in continuous operation for the five (5) years preceding the application;

C. The applicant submits financial information in sufficient detail to show one (1) of the following:

(I) The applicant has a current Moody's Investor Service or Standard and Poor's rating for its most recent bond issuance of A or higher;

(II) The applicant has a tangible net worth of at least ten (10) million dollars, a ratio of total liabilities to net worth of two and one-half (2 1/2) times or less and a ratio of current assets to current liabilities of 1.2 times or greater; or

(III) The applicant's fixed assets in the United States total at least twenty (20) million dollars and the applicant has a ratio of total liabilities to net worth of two and one-half (2 1/2) times or less and a ratio of current assets to current liabilities of 1.2 times or greater; and

D. The applicant submits—

(I) Financial statements for the last complete fiscal year, accompanied by a report prepared by an independent certified public accountant, in conformity with generally accepted accounting principles, containing the accountant's audit opinion or review opinion of the financial statements with no adverse opinion; *[and]*

(II) **Unaudited** *[F]***f**inancial statements for completed quarters in the current fiscal year**;** and

(III) *[a]***A**dditional **unaudited** information *[that may be]* **as** requested by the director.

3. Parent and Non-Parent Corporation Third-Party Guarantors.

A. The director may accept a written guarantee for an applicant's self-bond from a parent corporation guarantor, if the guarantor meets the conditions of subparagraphs (6)(D)2.A. through D. as if it were the applicant. Such a written guarantee shall be referred to as a "corporate guarantee." The terms of the corporate guarantee shall provide for the following:

(I) If the applicant fails to complete the reclamation plan, the guarantor shall do so or the guarantor shall be liable under the indemnity agreement to provide funds to the director sufficient to complete the reclamation plan, but not to exceed the bond amount.

(II) The corporate guarantee shall remain in force unless the guarantor sends notice of cancellation by certified mail to the applicant and to the director at least ninety (90) days in advance of the cancellation date, and the director accepts the cancellation.

(III) The cancellation may be accepted by the director if the applicant obtains suitable replacement bond before the cancellation date or if the lands for which the self-bond, or portion thereof, was accepted have not been disturbed.

[3.] **B.** The *[commission]* **director** may accept a written guarantee for an applicant's self-bond from a *[third-party]* **non-parent corporation** guarantor *[with a long-term vested interest in the surface coal mining operation,]* if the guarantor meets the conditions of **sub**paragraphs *[(5)(D)2.]* **(6)(D)2.A. through D.** as if it were the applicant. The applicant must still meet the requirements of subparagraphs *[(5)]* **(6)**(D)2.A., B. and D. of this rule. *[Copies of documents demonstrating that interest must be submitted to the director.]* The written guarantee shall provide for the following:

*[A.]***(I)** If the applicant fails to complete the reclamation plan, the guarantor shall do so or the guarantor shall be liable under the indemnity agreement to provide to the *[commission]* **director** funds, up to the bond amount, sufficient to complete the reclamation plan;

*[B.]***(II)** The **non-parent corporation** guarantee shall remain in force unless the guarantor sends notice of cancellation by certified mail to the applicant and to the director at least ninety (90) days in advance of the cancellation date and the director accepts the cancellation; and

*[C.]***(III)** The cancellation may be accepted by the director only if the applicant obtains suitable replacement bond before the cancellation or if the covered lands have not been disturbed.

4. The total amount of the outstanding and proposed self-bonds for surface coal mining and reclamation operations shall not exceed twenty-five percent (25%) of the applicant's or third-party guarantor's tangible net worth in the United States, as determined by a certified public accountant.

5. For a self-bond, the guarantor shall execute an indemnity agreement according to the following:

A. The indemnity agreement shall be executed and signed by all persons and parties who are to be bound by it, including the parent and non-parent corporations, and shall bind each jointly and severally. If the applicant is a partnership, joint venture or a syndicate, the agreement shall bind the partner or party who has a beneficial interest, directly or indirectly, in the applicant;

B. Corporations applying for a self-bond, and parent and non-parent corporations guaranteeing a permittee's self-bond, shall submit an indemnity agreement signed by two (2) corporate officers who are authorized to bind the corporations. A copy of the authorization shall be provided to the director along with an affidavit certifying that the agreement is valid under all applicable federal and state laws. In addition, the guarantor shall provide a copy of the corporate authorization demonstrating that the corporation may guarantee the self-bond and execute the indemnity agreement; and

C. Pursuant to 10 CSR 40-7.031(3), the applicant, parent and non-parent corporation shall be required to complete the approved reclamation plan for the lands in default or to pay to the *[regulatory authority]* **director** an amount necessary to complete the approved reclamation plan, not to exceed the bond amount. If permitted under state law, the indemnity agreement when under forfeiture shall operate as a judgement against those parties liable under the indemnity agreement.

6. Self-bonded permittees and third-party guarantors shall submit an update of the information required under subparagraphs *[(5)]* **(6)**(D)2. C. and D. within ninety (90) days after the close of their fiscal years.

7. If the financial conditions of the permittee or the third-party guarantor change so that the criteria of this section are not satisfied, the permittee shall notify the director immediately and post an alternate bond in the same amount as the self-bond.

8. Upon notification that the **financial** conditions of the permittee no longer satisfy this section, the permittee shall be deemed to be without bond coverage in violation of subsection (2)(A). The director shall issue a notice of violation against any operator who is without bond coverage. The notice shall specify a reasonable period to replace bond coverage, not to exceed *[sixty (60)]* **ninety (90)** days. During this period, the director or his/her authorized agent shall conduct weekly inspections to ensure continuing compliance with other permit requirements, the regulatory program and the law. The notice of violation, if abated within the period allowed, shall not be counted as a notice of violation for purposes of determining a pattern of willful violation under 10 CSR 40-7.031(1)(F)2. and need not be reported as a past violation in permit applications under 10 CSR 40-6.030(2) or 10 CSR 40-6.100(2). If a notice of violation is not abated in accordance with the schedule, a cessation order shall be issued requiring immediate compliance with 10 CSR 40-3.150(4). **The operator shall also immediately begin to conduct reclamation operations in accordance with the reclamation plan.** Mining operations shall not resume until the director has *[determned]* **determined** that an acceptable bond has been posted.

9. The bond shall be forfeitable upon revocation of the underlying permit.

(7) Replacement of Bonds.

(A) Permittees may replace existing surety or personal **or self-**bonds with other surety or personal **or self-**bonds, if the liability which has accrued against the permittee on the permit area is transferred to these replacement bonds.

AUTHORITY: section 444.810, RSMo [Supp. 1999] ***2000****. Original rule filed Dec. 9, 1982, effective April 11, 1983. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Dec. 1, 2005. Emergency amendment filed Dec. 21, 2005, effective Jan. 1, 2006, expires June 29, 2006.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 40—Land Reclamation Commission
Chapter 7—Bond and Insurance Requirements for Surface Coal Mining and Reclamation Operations

EMERGENCY AMENDMENT

10 CSR 40-7.021 Duration and Release of Reclamation Liability. The commission is amending sections (1) and (2) of this rule.

PURPOSE: This rule sets forth requirements for the duration and release of reclamation liability and bonding under the "full cost" bonding provisions of this chapter and removes the references to the existing bond "pool" system.

EMERGENCY STATEMENT: This emergency amendment addresses the steps to be taken in order for release of bonding to occur at surface coal mining operations. This emergency amendment is necessary because of a compelling governmental interest. Without this amendment the existing coal industry will be required to waste significant amounts of money and resources in order to comply with current rules only to change again when full cost bonding becomes effective later on in 2006 as described below. Additionally, federal monies will be lost that would otherwise be used to protect the public's safety and general welfare in the vicinity of old, abandoned coal mines as further described below. Therefore, this amendment is seen to be necessary in that it will provide for a seamless transition for the existing coal mining industry from the current federal regulation of this industry to one of state regulation. This transition from federal to state control is expected to take effect during January 2006.

Federal regulation requires full cost bonding which the coal industry is currently seeking to comply with. In fact all but one coal permit is adequately covered for full cost bonding. If this rule is not enacted as an emergency measure the industry would be mandated to comply with the current "bond pool" state regulation. This would require a complete replacement of most industry bonds in force at the present time. This would be burdensome on this industry in that the cost of replacing bonds and the time involved in doing so would be a significant financial impact on these businesses. To further this explanation, an additional burden would be realized by the coal mining industry when the normal, proposed rulemaking for this amendment becomes effective during the summer of 2006. After replacing all bonds to comply with existing "bond pool" state regulation, the industry would once again be required to replace all bonds to comply with the "full cost" bonding provisions of this amendment. Rather than put the industry through such a scenario of replacing bonds in January then replacing them again in August only to arrive at the same point they presently are, it seems justifiable to request that this emergency rulemaking become effective to keep the current federally mandated bonding requirements stable and uninterrupted in order to minimize the effects on the industry this amendment is designed to address.

Also, this emergency amendment is seen to be necessary in order to provide for protection of the public's health, safety, and general welfare. In order for the state to acquire primacy in the regulation of the coal mining industry from the federal government, including the administration and the receipt of federal monies for the implementation of the abandoned mined land program, this emergency

amendment to the existing rules must first be in place. The abandoned mined land program is a program where very old, pre-law coal mine sites are reclaimed by the state with monies provided by federal grant. Oftentimes, abandoned coal mined lands pose serious safety threats to the general public and, at times, health problems may also be realized in and around areas of past coal mining where no reclamation was ever required. If this emergency amendment is not placed into effect in January 2006, the federal grant monies will not be available to the State of Missouri in order to address the remediation of sites that pose a health and/or a safety issue for those citizens living in or around old, abandoned surface coal mines. These citizens are then left with no recourse other than to live with these imminent dangers to their health and/or safety other than to provide for remediation out of their own pockets. This is generally well beyond the financial reach of most ordinary citizens of the state.

A proposed amendment which covers this same material was published in the January 3, 2006 issue of the ***Missouri Register*** *(31 MoReg 32–33). The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Land Reclamation Commission believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed on December 21, 2005, effective January 1, 2006, expires June 29, 2006.*

(1) Period of Liability.

(A) Liability applicable to a permit shall continue until all reclamation, restoration and abatement work required of the permittee under the regulatory program and the provisions of the permit and **reclamation** plan *[has]* **have** been completed and the permit terminated by release of the permittee from any further liability in accordance with this rule.

(2) Criteria and Schedule for Release of Reclamation Liability. *[Except as described in subsection (2)(E),] [r]***R**eclamation liability shall be released in three (3) phases.

(A) An area shall qualify for release of Phase I liability upon completion of backfilling and grading, topsoiling, drainage control and initial seeding of the disturbed area. Phase I bond shall be retained on unreclaimed temporary structures, such as roads, siltation structures, diversions and stockpiles*[, on an acre-for-acre basis]*.

(B) An area shall qualify for release of Phase II liability when—

1. A permanent vegetative cover that meets the approved reclamation plan and is sufficient to control erosion is in place and no further augmentation of the vegetation is necessary;

2. With respect to woodlands and wildlife areas, the stocking of trees and shrubs has been established in accordance with 10 CSR 40-3.120(7) or 10 CSR 40-3.270(7);

3. The lands are not contributing suspended solids to stream flow or runoff outside the permit area in excess of the requirements of section 444.855.2(10), RSMo, 10 CSR 40-3 and 10 CSR 40-4, the regulatory program or the permit; *[and]*

4. A plan for achieving Phase III release has been approved for the area requested for release and the plan has been incorporated into the permit*[, except for the prime farmland soils in which case the soil productivity for prime farmlands shall have been returned to the equivalent levels of yield as nonmined land of the same soil type in the surrounding areas under equivalent management practices as determined from the soil survey performed pursuant to 10 CSR 40-4.030.]***;**

5. For the prime farmland soils, the soil productivity for prime farmlands shall have been returned to the equivalent levels of yield as non-mined land of the same soil type in the surrounding areas under equivalent management practices as determined from the soil survey performed pursuant to 10 CSR 40-4.030; and

6. Where a silt dam is to be retained as a permanent impoundment pursuant to 10 CSR 40-3.040(10), the Phase II portion of the bond may be released under this subsection as long as provisions for sound future maintenance by the operator or the landowner have been made with the director.

(C) An area shall qualify for release of Phase III liability when—

1. Vegetation has been established in accordance with the approved reclamation plan and the standards for the success of revegetation are met;

2. **As required by 10 CSR 40-6.060(4) and 10 CSR 40-4.030,** *[Soil]* **soil** productivity, with respect to prime farmlands, has been returned to the *[level of yield, as required by 10 CSR 40-6.060(4) and 10 CSR 40-4.030,]* equivalent *[to the]* **levels of** yield *[of nonmined]* **as non-mined** prime farmland of the same soil type *[under equivalent management practices]* in the surrounding area **under equivalent management practices**, as determined from the soil survey performed under section 444.820.2(16), RSMo and the plan approved under 10 CSR 40-6.060(4);

3. The permittee has successfully completed all surface coal mining and reclamation operations in accordance with the approved reclamation plan so that the land is capable of supporting any post-mining land use approved pursuant to 10 CSR 40-3.130 or 10 CSR 40-3.300;

4. The permittee has achieved compliance with the requirements of the law, the regulatory program and the permit; and

5. The applicable liability period under section 444.855.2(20), RSMo and this rule has expired.

(D) Bond*[s shall be released as follows:]* **Release.**

[1. Phase I bonds shall be reduced by eighty percent (80%) when Phase I liability is released, except that the total remaining bond for a single permit shall not be below the amount required by 10 CSR 40-7.011(4)(B); and

2. The remaining amount of the bonds shall be released when Phase III liability is released.]

1. Phase I—After the operator completes the backfilling, grading, topsoiling, drainage control, and initial seeding of the disturbed area in accordance with the approved reclamation plan, the director may release sixty percent (60%) of the bond for the applicable area.

2. Phase II—After vegetation has been established on the regraded mined lands in accordance with the approved reclamation plan, the director may release an additional amount of bond. When determining the amount of bond to be released after successful vegetation has been established, the director shall retain that amount of bond for the vegetated area which would be sufficient to cover the cost of reestablishing vegetation if completed by a third party and for the period specified in 10 CSR 40-7.021(1)(B) for reestablishing vegetation.

3. Phase III—After the operator has completed successfully all surface coal mining and reclamation activities, the director may release the remaining portion of the bond, but not before the expiration period specified for the period of liability in 10 CSR 40-7.021(1)(B).

(E) *[All bonding liability may be released in full from undisturbed areas when further disturbances from surface mining have ceased. No bonding shall be released from undisturbed areas before Phase I liability applying to adjacent disturbed lands is released, except that the commission may approve a separate bond release from an area of undisturbed land if the area is not excessively small and can be separated from areas that have been or will be disturbed by a distinct boundary, which can be easily located in the field and which is not so irregular as to make record keeping unusually difficult.]* The permit shall terminate on all areas where all bonds have been released.

AUTHORITY: section 444.810, RSMo [Supp. 1999] ***2000****. Original rule filed Dec. 9, 1982, effective April 11, 1983. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Dec. 1, 2005. Emergency amendment filed Dec. 21, 2005, effective Jan. 1, 2006, expires June 29, 2006.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 40—Land Reclamation Commission
Chapter 7—Bond and Insurance Requirements for Surface Coal Mining and Reclamation Operations

EMERGENCY AMENDMENT

10 CSR 40-7.031 Permit Revocation, Bond Forfeiture and Authorization to Expend Reclamation Fund Monies. The commission is amending sections (2), (3) and (4) of this rule.

PURPOSE: This rule clarifies, revises and sets forth requirements, criteria and procedures for permit revocation, bond forfeiture and authorization to expend reclamation fund monies pursuant to sections 444.810, 444.830, 444.885, 444.960 and 444.970, RSMo.

EMERGENCY STATEMENT: This emergency amendment addresses the forfeiture of bond monies and authorizes expenditures of that money for reclamation of surface coal mined lands. This emergency amendment is necessary because of a compelling governmental interest. Without this amendment the existing coal industry will be required to waste significant amounts of money and resources in order to comply with current rules only to change again when full cost bonding becomes effective later on in 2006 as described below. Additionally, federal monies will be lost that would otherwise be used to protect the public's safety and general welfare in the vicinity of old, abandoned coal mines as further described below. Therefore, this amendment is seen to be necessary in that it will provide for a seamless transition for the existing coal mining industry from the current federal regulation of this industry to one of state regulation. This transition from federal to state control is expected to take effect during January 2006.

Federal regulation requires full cost bonding which the coal industry is currently seeking to comply with. In fact all but one coal permit is adequately covered for full cost bonding. If this rule is not enacted as an emergency measure the industry would be mandated to comply with the current "bond pool" state regulation. This would require a complete replacement of most industry bonds in force at the present time. This would be burdensome on this industry in that the cost of replacing bonds and the time involved in doing so would be a significant financial impact on these businesses. To further this explanation, an additional burden would be realized by the coal mining industry when the normal, proposed rulemaking for this amendment becomes effective during the summer of 2006. After replacing all bonds to comply with existing "bond pool" state regulation, the industry would once again be required to replace all bonds to comply with the "full cost" bonding provisions of this amendment. Rather than put the industry through such a scenario of replacing bonds in January then replacing them again in August only to arrive at the same point they presently are, it seems justifiable to request that this emergency rulemaking become effective to keep the current federally mandated bonding requirements stable and uninterrupted in order to minimize the effects on the industry this amendment is designed to address.

Also, this emergency amendment is seen to be necessary in order to provide for protection of the public's health, safety, and general welfare. In order for the state to acquire primacy in the regulation of the coal mining industry from the federal government, including the administration and the receipt of federal monies for the implementation of the abandoned mined land program, this emergency amendment to the existing rules must first be in place. The abandoned mined land program is a program where very old, pre-law coal mine sites are reclaimed by the state with monies provided by federal grant. Oftentimes, abandoned coal mined lands pose serious safety threats to the general public and, at times, health problems may also be realized in and around areas of past coal mining where no reclamation was ever required. If this emergency amendment is not placed into effect in January 2006, the federal grant monies will not be available to the State of Missouri in order to address the remediation of sites that pose a health and/or a safety issue for those citizens living in or around old, abandoned surface coal mines. These citizens are then left with no recourse other than to live with these imminent dangers to their health and/or safety other than to provide for remediation out of their own pockets. This is generally well beyond the financial reach of most ordinary citizens of the state.

A proposed amendment which covers this same material was published in the January 3, 2006 issue of the ***Missouri Register*** *(31 MoReg 33–34). The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Land Reclamation Commission believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed on December 21, 2005, effective January 1, 2006, expires June 29, 2006.*

(2) Procedures.

(E) In lieu of the hearing provided for in subsection (2)(B) of this rule, the commission either may—

1. Enter into a consent order with the permittee to correct the underlying causes of the show-cause order if the consent agreement will not unreasonably delay reclamation *[and will not result in an increase in liability to the reclamation fund]*; or

2. Extend*[,]* **the abatement period as follows** if the cause of the show-cause order is a failure to abate a notice of delinquent reclamation within the time established for the abatement*[, extend the abatement period as follows]*:

A. The extension of the abatement period shall be set by the commission and shall not exceed one (1) year from the abatement date established pursuant to 10 CSR 40-8.030(18)(B) or (C) that the permittee did not meet;

B. An extension may only be approved if the commission finds that the failure to abate the notice of delinquent reclamation is not due to a lack of diligence by the permittee*[;]***.**

[C. The permittee shall submit a bond to compensate for the additional liability an extension represents to the Coal Mine Land Reclamation Fund. The amount of the bond shall be one hundred twenty-five percent (125%) of the amount the commission finds would be needed to complete the reclamation plan of the area to which the extension will apply; and

D. Within fifteen (15) days after a commission decision to extend the abatement period, the permittee shall furnish to the director an estimate of the cost of completing the reclamation plan of the area to which the extension will apply. The director shall review the permittee's estimate and recommend a bond amount to the commission within thirty (30) days after the decision to extend the abatement period. Within forty-five (45) days after the decision to extend the abatement period, the commission shall set the bond amount. Within thirty (30) days after the commission sets the bond amount, the permittee shall submit a bond of that amount to the director. The bond shall be submitted on a form provided by the commission and shall be conditioned upon abatement of the notice of delinquent reclamation by the date established pursuant to subparagraph (2)(E)2.A.]

(3) Bond Forfeiture.

(C) The entry of an order declaring a bond forfeited shall automatically authorize the director, *[him/herself or]* with the assistance of the attorney general, **if necessary,** to take whatever actions are necessary to collect the forfeited bond and any instruments securing the bond.

(4) *[A declaration]* **Declaration** of *[p]***P**ermit *[r]***R**evocation**.** *[shall authorize the commission to utilize duly appropriated reclamation fund monies as specified in 10 CSR 40-7.041(4) to*

ensure compliance with all applicable regulations and satisfactory completion of the reclamation plan.]

(A) For bonds forfeited before January 1, 2006, the director is authorized to utilize duly appropriated reclamation fund monies as specified in 10 CSR 40-7.041(1) to ensure compliance with all applicable regulations and satisfactory completion of the reclamation plan;

(B) For bonds forfeited on or after January 1, 2006, the director is authorized to utilize forfeited bonds to ensure compliance with all applicable regulations and satisfactory completion of the reclamation plan.

1. In the event the estimated amount forfeited is insufficient to pay for the full cost of reclamation, the operator shall be liable for remaining costs. The director may complete or authorize completion of reclamation of the bonded area and may recover from the operator all costs of reclamation in excess of the amount forfeited.

2. In the event the amount of performance bond forfeited is more than the amount necessary to complete reclamation, the unused funds shall be returned by the director to the party from whom they were collected.

AUTHORITY: section 444.810, RSMo [1994] ***2000****. Original rule filed Dec. 9, 1982, effective April 11, 1983. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Dec. 1, 2005. Emergency amendment filed Dec. 21, 2005, effective Jan. 1, 2006, expires June 29, 2006.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 40—Land Reclamation Commission
Chapter 7—Bond and Insurance Requirements for Surface Coal Mining and Reclamation Operations

EMERGENCY AMENDMENT

10 CSR 40-7.041 Form and Administration of the Coal Mine Land Reclamation Fund. The commission is deleting sections (1), (2) and (3) of this rule and amending sections (4) and (5).

PURPOSE: This rule sets forth requirements for administration of the Coal Mine Land Reclamation Fund pursuant to sections 444.960, 444.965 and 444.970, RSMo.

EMERGENCY STATEMENT: This emergency amendment addresses the administration of the coal mine land reclamation fund and replaces "commission" with "director." This emergency amendment is necessary because of a compelling governmental interest. Without this amendment the existing coal industry will be required to waste significant amounts of money and resources in order to comply with current rules only to change again when full cost bonding becomes effective later on in 2006 as described below. Additionally, federal monies will be lost that would otherwise be used to protect the public's safety and general welfare in the vicinity of old, abandoned coal mines as further described below. Therefore, this amendment is seen to be necessary in that it will provide for a seamless transition for the existing coal mining industry from the current federal regulation of this industry to one of state regulation. This transition from federal to state control is expected to take effect during January 2006.

Federal regulation requires full cost bonding which the coal industry is currently seeking to comply with. In fact all but one coal permit is adequately covered for full cost bonding. If this rule is not enacted as an emergency measure the industry would be mandated to comply with the current "bond pool" state regulation. This would require a complete replacement of most industry bonds in force at the present time. This would be burdensome on this industry in that the cost of replacing bonds and the time involved in doing so would be a significant financial impact on these businesses. To further this explanation, an additional burden would be realized by the coal mining industry when the normal, proposed rulemaking for this amendment becomes effective during the summer of 2006. After replacing all bonds to comply with existing "bond pool" state regulation, the industry would once again be required to replace all bonds to comply with the "full cost" bonding provisions of this amendment. Rather than put the industry through such a scenario of replacing bonds in January then replacing them again in August only to arrive at the same point they presently are, it seems justifiable to request that this emergency rulemaking become effective to keep the current federally mandated bonding requirements stable and uninterrupted in order to minimize the effects on the industry this amendment is designed to address.

Also, this emergency amendment is seen to be necessary in order to provide for protection of the public's health, safety, and general welfare. In order for the state to acquire primacy in the regulation of the coal mining industry from the federal government, including the administration and the receipt of federal monies for the implementation of the abandoned mined land program, this emergency amendment to the existing rules must first be in place. The abandoned mined land program is a program where very old, pre-law coal mine sites are reclaimed by the state with monies provided by federal grant. Oftentimes, abandoned coal mined lands pose serious safety threats to the general public and, at times, health problems may also be realized in and around areas of past coal mining where no reclamation was ever required. If this emergency amendment is not placed into effect in January 2006, the federal grant monies will not be available to the State of Missouri in order to address the remediation of sites that pose a health and/or a safety issue for those citizens living in or around old, abandoned surface coal mines. These citizens are then left with no recourse other than to live with these imminent dangers to their health and/or safety other than to provide for remediation out of their own pockets. This is generally well beyond the financial reach of most ordinary citizens of the state.

A proposed amendment which covers this same material was published in the January 3, 2006 issue of the ***Missouri Register*** *(31 MoReg 34–35). The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Land Reclamation Commission believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed on December 21, 2005, effective January 1, 2006, expires June 29, 2006.*

[(1) Payment of Assessments.

(A) Until enough monies have accumulated in the forty percent (40%) pool to complete all reclamation of those permits that have been revoked by the commission prior to September 1, 1988, every permittee shall pay an assessment into the Coal Mine Land Reclamation Fund, established under section 444.960, RSMo. This fund shall be administered by the commission in accordance with the provisions of this rule.

(B) After enough monies have accumulated pursuant to subsection (1)(A) of this rule, the commission may reinstate payments in accordance with subsection (1)(E), when necessary, to assure that the Coal Mine Land Reclamation Fund balance is sufficient for its purpose.

1. For permittees who file Phase I bonds before enough monies have accumulated pursuant to subsection (1)(A) of this rule, the assessment rate shall be forty-five cents (45¢) per ton of coal for the first fifty thousand (50,000) tons, and thirty cents (30¢) per ton for the next fifty thousand (50,000) tons that are sold, shipped or otherwise disposed of by each permittee from his/her Missouri operation(s) in a calendar year or that portion of a calendar year in which assessments are in effect. Assessments shall be paid to the

commission on a monthly basis and shall be due fifteen (15) days after the end of the month for which an assessment is applicable. The director shall transfer any payment to the state treasurer for deposit in the Coal Mine Land Reclamation Fund.

2. Each monthly payment shall be accompanied by a notarized statement of the tonnage of coal sold, shipped or otherwise disposed of. The director shall check the accuracy of these statements against the tonnage reported on the Quarterly Fee Statement submitted to the Division of Labor Standards. If there is discrepancy between the Quarterly Fee Statement and the corresponding three (3)-month total reported in the monthly statements, the permittee shall be considered delinquent in payment and the director shall impose a penalty and take other actions as warranted pursuant to section (3).

(C) Permittees shall continue to pay monthly assessments as per paragraph (1)(B)1. until enough monies have accumulated pursuant to subsection (1)(A) of this rule, unless, at the end of a fiscal year, the fund balance is more than seven (7) million dollars.

(D) Compensative Assessments. Any new permittee who files a Phase I bond and received his/her first permit on or after September 1, 1988 shall be liable for compensative assessments.

1. The compensative assessments shall be paid only after regular assessments under paragraph (1)(B)1. have ceased.

2. The compensative assessments shall be paid regardless of the fund balance.

3. The compensative assessments shall begin the month the permit is issued or when regular assessments cease, whichever is later, and shall be paid monthly at a rate equal to the rate paid for regular assessments under paragraph (1)(B)1.

4. Compensative assessments shall continue until the permittee has paid for a number of months equal to the number of months for which assessments were in effect between September 1988 and the month and year in which his/her first permit was received or until regular assessments are reinstated, whichever comes first.

(E) Reinstatement Rates.

1. Reinstated assessments will only apply to permittees who file Phase I bonds.

2. After the date when enough monies have accumulated pursuant to subsection (1)(A) of this rule, and whenever the fund balance is below seven (7) million dollars, the assessment established in subsection (1)(A) of this rule shall be reinstated at a rate of twenty-five cents (25¢) for the first fifty thousand (50,000) tons and fifteen cents (15¢) for the second fifty thousand (50,000) tons of coal sold in a calendar year. The reinstated rate shall remain in effect until the fund balance reaches seven (7) million dollars or until September 1, 1998, whichever comes first.

3. After September 1, 1998, whenever the fund balance is below two (2) million dollars, the assessment established in subsection (1)(A) of this rule shall be reinstated at a rate of thirty cents (30¢) for the first fifty thousand (50,000) tons and twenty cents (20¢) for the second fifty thousand (50,000) tons of coal sold in a calendar year. This reinstated rate shall remain in effect until the fund balance reaches three (3) million dollars, at which time the assessment will revert to the rate established in paragraph (1)(E)2. of this rule.

4. The commission shall inform permittees by certified mail of the application of a reinstated rate, the termination of a reinstated rate and the termination of assessments pursuant to subsection (1)(B).

5. Any application of a reinstated rate shall be effective on the first day of the month following that in which notice of reinstatement is given by the commission. Any termination of a reinstated rate or termination of assessments shall be effective retroactive to the first day of the month in which notice of is given by the commission.

(2) Fund Ceiling and Reimbursements.

(A) At the first commission meeting following the end of a fiscal year, the director shall report the balance of the Reclamation Fund to the commission. If the balance is greater than the maximum amount as stated in subsection (1)(C) or paragraph (1)(E)2. or 3. of this rule, the commission shall refund the excess to the permittees filing Phase I bonds and having valid permanent program permits at the end of the previous fiscal year, except that permittees subject to compensative payments under subsection (1)(D) of this rule shall be refunded only the amount which is in excess of what is due in compensative payments. Each permittee shall be refunded a fraction of the excess equal to the amount s/he paid into the fund under paragraph (1)(A)1., exclusive of penalties, since September 1, 1988 divided by the total amount paid into the fund, exclusive of penalties, since September 1, 1988 by all permittees who qualify for a refund.

(3) Penalties for Delinquent Payment of Fees. If an assessment required under section (1) is not received within forty-five (45) days after the end of a month for which the assessment is applicable, the permittee shall be considered delinquent in payment.

(A) The director shall issue a notice of violation when a permittee becomes delinquent in payment. The time set for abatement of the notice of violations shall be ten (10) days. No extension of the abatement period may be granted.

(B) In addition to penalties pursuant to 10 CSR 40-8.040, a penalty of twenty-five cents (25¢) per ton of coal sold, shipped or otherwise disposed of during the month for which payment is delinquent shall be automatically imposed. The penalty shall be due at the end of the ten (10)-day abatement period and shall be credited to the Coal Mine Land Reclamation Fund.

(C) Failure to abate the notice of violation described under subsections (3)(A) and (B) shall result in the issuance of a cessation order in accordance with 10 CSR 40-8.030(6)(B).]

[(4)] **(1)** Expenditure of Reclamation Fund Monies.

(A) After revocation of a permit and forfeiture of the associated bonds, Reclamation Fund monies shall be used by the *[commission]* **director** to complete reclamation pursuant to the approved reclamation plan*[, as specified in the following]* and shall be used for administrative costs to the commission resulting directly from activities necessary to complete reclamation*[:]***.**

[1.] All monies assessed for the Coal Mine Land Reclamation Fund after September 1, 1988, *[shall be]* **are** allocated so that forty percent (40%) of the assessments *[shall be]* **are** applied to the reclamation of those permits that have been revoked by the commission prior to September 1, 1988, and sixty percent (60%) of the assessments *[shall be]* **are** applied to the reclamation of those permits that have been revoked by the commission after September 1, 1988. All monies within the Coal Mine Land Reclamation Fund as of September 1, 1988, *[shall be]* **are** allocated to forfeitures which occurred before September 1, 1988. *[After the date when enough monies have accumulated pursuant to subsection (1)(A) of this rule, all monies assessed to the Coal Mine Land Reclamation Fund shall be allocated to forfeitures occurring on or after September 1, 1998.]* The monies within the fund

may be utilized by the *[commission]* **director** on any phase of reclamation.

(B) Proceeds from any collectable performance bonds shall be expended or committed to specific aspects of reclamation to which the bonds apply before Reclamation Fund monies are employed to complete those aspects of reclamation, except that—

1. Reclamation Fund monies may be expended by the *[commission]* **director** before proceeds from bonds are expended or committed when the expenditure will result in a net savings to the Reclamation Fund; and

2. Reclamation Fund monies shall be expended by the *[commission]* **director** before proceeds from bonds are expended or committed when expeditious work is necessary to comply with the laws, regulations, conditions of the permit or reclamation plan. This work may include, but shall not be limited to, treatment of acid mine drainage, erosion control and maintenance of water control structures.

(C) No Reclamation Fund monies may be used to correct disturbances that were caused by a person who did not have a duly approved permanent program permit.

[(5)] **(2)** Reimbursement of the Reclamation Fund.

(A) If a permittee fails to complete a reclamation plan and the completion must be made by or on behalf of the commission, the permittee or any principal of the permittee or any entity in which a principal of the permittee is a principal or any entity controlled by or under common control with the permittee shall not operate a coal mining operation in Missouri until the costs of the completion have been fully paid by the permittee to the Reclamation Fund.

(B) The amount to be repaid to the Reclamation Fund shall include the interest that the state treasurer could have earned on the monies expended if the expenditure had not been made.

(C) The commission shall pursue all legal remedies available to it to recover monies expended from the Reclamation Fund from the responsible permittee, except where the commission in its sole judgment determines that the cost of pursuing the legal remedies will be greater than the sums expected to be recovered. The cost of pursuing the legal remedies shall be charged to the Reclamation Fund.

AUTHORITY: section 444.810, RSMo [1994] ***2000****. Original rule filed Dec. 9, 1982, effective April 11, 1983. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Dec. 1, 2005. Emergency amendment filed Dec. 21, 2005, effective Jan. 1, 2006, expires June 29, 2006.*

Title 20—DEPARTMENT OF INSURANCE
Division 400—Life, Annuities and Health
Chapter 2—Accident and Health Insurance in General

EMERGENCY RULE

20 CSR 400-2.170 Early Intervention Part C Coverage

PURPOSE: This rule implements the requirements of section 376.1218, RSMo, with respect to the Missouri early intervention system and clarifies insurance carriers' obligations under the new law.

EMERGENCY STATEMENT: This emergency rule is necessary to preserve the public welfare of Missouri citizens by ensuring that insurance carriers understand their obligations under the First Steps legislation, passed in 2005 as Senate Bill 500, before the effective date of January 1, 2006. As a result, the Missouri Department of Insurance finds an immediate danger to the public welfare and a compelling governmental interest which requires emergency action. The scope of this emergency rule is limited to the conditions creating the emergency and complies with the protections extended in the ***Missouri*** *and* ***United States Constitutions****. In developing this emergency rule, representatives of the insurance industry were consulted. The department believes this emergency rule is fair to all interested persons and parties under the circumstances. A proposed rule, which covers the same material, is published in this issue of the* ***Missouri Register****. This emergency rule was filed December 20, 2005, effective January 1, 2006, expires June 29, 2006.*

(1) Definitions: The terms used in this rule or in section 376.1218, RSMo, shall have the following meanings:

(A) "Assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain or improve the functional capabilities of children with disabilities.

(B) "Direct written premium" means:

1. The total amount of premium reported for health benefit plans, as defined in 376.1350, RSMo, on the Annual Statement Supplement for the State of Missouri for health carriers required to file this supplement; or

2. The total amount of premium reported for health benefit plans, as defined in 376.1350, RSMo, on the Exhibit of Premiums, Enrollment, and Utilization for the State of Missouri included in the health carrier's annual financial statement, for all other health carriers not covered in paragraph (1)(B)1.

(C) "Early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq.

(D) "First Steps" refers to the Missouri early intervention system under the federal Infant and Toddler Program, Part C of the Individuals with Disabilities Act, 20 U.S.C. Section 1431, et seq.

(E) "Group of carriers affiliated by or under common ownership or control" means health carriers with a common four (4)-digit group code as assigned by the National Association of Insurance Commissioners.

(F) "Health benefit plan," "health care professional," and "health carrier" shall each have their respective meanings as such terms are defined in 376.1350, RSMo.

(G) "Individualized family service plan" means a written plan for providing early intervention services to an eligible child and the child's family, that is adopted in accordance with 20 U.S.C. Section 1436.

(H) "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier.

(2) Health Carriers to Recognize First Steps as Provider.

(A) First Steps shall be considered the rendering provider for all claims covered under section 376.1218, RSMo, and this rule.

(B) First Steps shall be considered a participating and/or network provider by all health carriers. All health carriers shall use the Missouri standardized credentialing form or the Federal W-9 tax form to establish network provider status for First Steps. Health carriers shall take all necessary steps to assure that claims submitted by First Steps are not denied, delayed, or reduced for reasons related to network participation.

(3) Requirements for Acceptance and Payment of Claims.

(A) Health carriers shall have the option to pay claims for First Steps services in one (1) of three (3) ways:

1. A health carrier shall pay individual claims submitted for each service to First Steps as the rendering provider, and such coverage shall be limited to three thousand dollars ($3,000) for each covered child per policy per calendar year, with a lifetime policy maximum of nine thousand dollars ($9,000) per child. Such payments

shall not exceed one-half of one percent (0.5%) of the direct written premium for health benefit plans; or

2. A health carrier and all of its affiliates together shall submit a lump sum payment to First Steps for one-half of one percent (0.5%) of the direct written premiums reported to the Department of Insurance on each health carrier's most recently filed annual financial statement, per calendar year, which shall satisfy each affiliated health carrier's payment obligation for First Steps services for such calendar year; or

3. A health carrier and all of its affiliates shall make a lump sum payment of five hundred thousand dollars ($500,000), per calendar year, to First Steps, which shall satisfy the health carrier and its affiliates' payment obligation for First Steps services for such calendar year.

4. As between paragraphs 2. and 3. of this subsection, the health carrier shall pay whichever amount is less.

(B) Payment of individually submitted claims under paragraph (3)(A)1. shall be subject to the requirements of sections 376.383 and 376.384, RSMo, as of January 1, 2007.

(C) For health carriers opting to make payments on individual claims under paragraph (3)(A)1.:

1. Such health carriers shall be responsible for keeping records to determine when the maximum three thousand dollars ($3,000) per child, per policy, per calendar year has been reached. If there is an irreconcilable discrepancy between a health carrier's records and Missouri Department of Elementary and Secondary Education (DESE) records, DESE's records shall prevail.

2. Such health carriers shall amend their applicable coverage documents to reflect First Steps benefits, and may do so by endorsement.

A. Such documents shall contain the same or substantially the same benefit description as stated in section 376.1218, RSMo, subsection 1.

3. Health carriers shall receive and issue payment for First Steps claims.

A. All claim payments shall be sent to DESE's designee.

B. Health carriers shall submit all First Steps remittance advices to DESE's designee in an electronic format consistent with federal administrative simplification standards, format and content adopted pursuant to the Health Insurance Portability and Accountability Act of 1996. Such remittance advices shall be submitted in a format agreed to by DESE.

C. Health carriers shall not deny, delay or reduce payment of First Steps claims based on their own determination of medical necessity or diagnosis, but shall in all cases defer to the services stated on the individual family service plan.

D. Health carriers shall not bundle claims for First Steps services.

E. For all adjustments on claim overpayments, such health carriers shall submit to DESE's designee in an electronic format consistent with federal administrative simplification standards, format and content adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, remittance advices on a per claim adjustment reflecting the individual and cumulative claim adjustment. Such remittance advices shall be submitted in a format agreed to by DESE.

4. Coordination of benefits requirements.

A. Failure of a parent or guardian to elect to assign a right of recovery or indemnification to the First Steps program shall not reduce claim payments to First Steps from secondary plans as defined in 20 CSR 400-2.030.

B. Notification from DESE that a primary plan, as defined in 20 CSR 400-2.030, has submitted a lump sum payment under paragraphs (3)(A)2. or 3. shall be sufficient notice to a secondary plan that such primary plan has fulfilled its payment obligations for First Steps services for that year.

(D) Health carriers shall accept and reimburse First Steps claims up to one (1) year after the date of service. Health carriers that otherwise require participating providers to submit claims in a shorter period of time than one (1) year shall waive this requirement for First Steps claims.

1. Health carriers that allow more than one (1) year for claims submission shall allow the same amount of time for First Steps claims submissions.

(E) There will be a presumption that the charges for First Steps services provided under section 376.1218, RSMo, and this rule, are being billed at the applicable Medicaid rate for such services.

(F) Health carriers electing a lump sum payment under paragraph (3)(A)2. or 3. will be invoiced by DESE after January 1 of each year, with payments due no later than January 31 of that year. The lump sum payment shall be due no later than January 31 of each year regardless of the effective dates of the individual insurance plans.

(G) Health carriers that elect a lump sum payment under paragraph (3)(A)2. or 3. and then fail to make such payment no later than January 31 of that year, shall be considered in violation of insurance law and be subjected to penalty, as allowed under the insurance laws of the state of Missouri.

(H) Lump sum payments under paragraphs (3)(A)2. and 3. shall not be credited against any health benefit plan lifetime maximum aggregates.

(I) For health carriers electing the lump sum payment option under paragraph (3)(A)2., the amount of direct written premium used to determine such health carriers' payment obligations for First Steps services will be the amount on record with the Missouri Department of Insurance on the most recently filed annual financial statement and any filed amendments as of September 1 of each year.

(4) Prior Authorization.

(A) Health carriers shall not require prior authorization for First Steps treatments and shall not deny, delay or reduce claim payments for failure to obtain prior authorization.

(5) Transactions Affecting Affiliation of Health Carriers.

(A) In the event of a transaction affecting affiliation of health carriers, the NAIC group code as of December 31 of the preceding year that payment for First Steps claims is due will determine affiliation of health carriers, and also, the total amount due to DESE if the applicable health carriers elect a lump sum payment option under paragraphs (3)(A)2. and 3.

*AUTHORITY: sections 374.045, RSMo 2000 and 376.1218, RSMo Supp. 2005. Emergency rule filed Dec. 20, 2005, effective Jan. 1, 2006, expires June 29, 2006. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 20—DEPARTMENT OF INSURANCE
Division 700—Licensing
Chapter 6—Bail Bond Agents and Surety Recovery Agents

EMERGENCY AMENDMENT

20 CSR 700-6.100 *Applications,* Fees and Renewals—Bail Bond Agents, General Bail Bond Agents and Surety Recovery Agents. The department is amending the title, Purpose, adding new sections (1) and (4) and amending and renumbering the original sections (1) and (2).

PURPOSE: This amendment clarifies the application requirements for initial and renewal applicants for a bail bond agent, general bail bond agent or surety recovery agent license.

*PURPOSE: This rule [sets the license and renewal fees] **establishes initial and renewal application requirements** for bail bond*

***agents**, general bail bond agents and surety recovery agents under sections 374.700–374.789, RSMo Supp. 2004.*

*EMERGENCY STATEMENT: This emergency amendment contains application and renewal requirements for the licensing of general bail bond, bail bond and surety recovery agents, including revisions to the application and renewal forms and addition of an electronic fingerprinting requirement. This emergency amendment is necessary to protect the public health, safety and welfare of Missouri citizens by ensuring the prompt, complete and legally compliant licensing, adequate background screening and accurate identification of qualified bail bond and surety recovery applicants pursuant to section 374.715 of the **Revised Statutes of Missouri** and Supreme Court Rule 33.17. The means for such prompt, complete and legally compliant licensing, adequate background screening and accurate identification of qualified bail bond and surety recovery applicants is currently not possible absent this regulation and the need for such means recently became apparent to the department. As a result, the Missouri Department of Insurance finds an immediate danger to the public health, safety and/or welfare and a compelling governmental interest, which requires emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the conditions creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed January 3, 2006, effective January 13, 2006, expires July 11, 2006.*

(1) Application Forms. The following forms have been adopted and approved for filing with the department:

(A) The Missouri Uniform Application For Bail Bond or Surety Recovery License form (Form B1), revised December 2005, or any form which substantially comports with the specified form; and

(B) The Missouri Uniform Renewal Application For Bail Bond Or Surety Recovery License form (Form BR), revised December 2005, or any form which substantially comports with the specified form.

(2) Application and Fees.

(A) Initial License. The following shall be included in an initial application for license:

1. Form B1 and required attachments;

[(1)] **2.** *[Each application for license as a general bail bond agent, bail bond agent or surety recovery agent must be accompanied by]* **Payment of** a licensing fee of one hundred fifty dollars ($150) for the two (2)-year license*[. The fee for renewal of the license shall also be one hundred fifty dollars ($150) for a biennial license.]***; and**

3. A fingerprint-based background check through the Missouri Highway Patrol.

(B) Renewal License. The following shall be included in renewal application for license:

1. Form BR and required attachments;

2. Payment of a licensing renewal fee of one hundred fifty dollars ($150) for the two (2)-year license;

3. If an approved fingerprint was not provided with the initial license application, a fingerprint-based background check through the Missouri Highway Patrol.

[(2)] **(3)** **Failure to Timely Apply for Renewal.** If a general bail bond agent, bail bond agent or surety recovery agent fails to file for renewal of his/her license on or before the expiration date, the Department of Insurance will issue a renewal of the license upon payment of a late renewal fee of twenty-five dollars ($25) per month or fraction of a month after the renewal deadline. In the alternative to payment of a late renewal fee, the former licensee may apply for a new license except that the former licensee must comply with all provisions of sections 374.710 and 374.784, RSMo regarding issuance of a new license.

(4) Availability of Forms. The department on request will supply in printed format the forms listed in this rule. Accurate reproduction of the forms may be utilized for filing in lieu of the printed forms. All application forms referenced herein are available at http://www.insurance.mo.gov.

*AUTHORITY: sections 374.045, RSMo 2000 and 374.705, 374.710, 374.730, 374.783, 374.784 and 374.786, RSMo Supp. 2004. Original rule filed March 14, 1994, effective Sept. 30, 1994. Amended: Filed Sept. 14, 2004, effective March 30, 2005. Emergency amendment filed Jan. 3, 2006, effective Jan. 13, 2006, expires July 11, 2006. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RESCISSION

22 CSR 10-2.010 Definitions. This rule established policies of the board regarding key terms within the Missouri Consolidated Health Care Plan relative to state members.

PURPOSE: This rule is being rescinded and a new rule with the same subject matter is being proposed in its place.

*EMERGENCY STATEMENT: This emergency rescission must take effect by January 1, 2006, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2006, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 22, 2005, effective January 1, 2006, expires June 29, 2006.*

*AUTHORITY: section 103.059, RSMo 2000. 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 Dec. 22, 2005, effective Jan. 1, 2006, expires June 29, 2006. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.010 Definitions

PURPOSE: This rule establishes the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan relative to state members.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2006, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2006, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 22, 2005, effective January 1, 2006, expires June 29, 2006.*

(1) Accident. An unforeseen and unavoidable event resulting in an injury which is not due to any fault or misconduct on the part of the person injured.

(2) Actively at work. You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday.

(3) Administrative appeal. Appeal procedures involving Missouri Consolidated Health Care Plan (MCHCP) administrative issues such as eligibility, effective date of coverage, etc.

(4) Administrative guidelines. The interpretation of the plan document as approved by the plan administrator, developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered.

(5) Adverse determination. When the claims administrator reviews an admission, availability of care, continued stay or other health care service and decides that it is not medically necessary, appropriate or effective. Therefore, payment for the requested service is denied, reduced or terminated.

(6) Allowable expense. Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible, coinsurance, or table of allowance included in the program.

(7) Automatic reinstatement maximum. The maximum annual amount that can be reinstated to an individual's lifetime benefit.

(8) Benefit year. The twelve (12)-month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the benefit year.

(9) Benefits. Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.

(10) Care Support Program. A voluntary program that helps manage a chronic condition with outpatient treatment.

(11) Claims administrator. An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs, including but not limited to the preferred provider organization (PPO) (also known as the co-pay plan) and health maintenance organization (HMO) type plans.

(12) Co-pay plan. A set of benefits similar to a health maintenance organization option.

(13) Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.

(14) Covered benefits. A schedule of covered services and charges, including chiropractic services, which are payable under the plan. The benefits covered under each type of plan are outlined in the applicable rule in this chapter.

(15) Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider or that do not entail or require the continuing attention of trained medical or paramedical personnel.

(16) Deductible. The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.

(17) Dependent-only participation. Participation of certain survivors of employees. Dependent participation may be further defined to include the deceased employee's:

(A) Spouse only;

(B) Child(ren) only; or

(C) Spouse and child(ren).

(18) Dependents. The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan.

(19) Diagnostic charges. The usual and customary charges (UCR) or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

(20) Disposable supplies. Do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

(21) Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

(22) Eligibility date. Refer to 22 CSR 10-2.020 for effective date provisions.
(A) Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.
(B) Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation subject to any applicable pre-existing conditions as outlined in the plan document.
(C) Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.
(D) Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation.

(23) Emancipated child(ren). A child(ren) who is:
(A) Employed on a full-time basis;
(B) Eligible for group health benefits in his/her own behalf;
(C) Maintaining a residence separate from his/her parents or guardian, except for full-time students in an accredited school or institution of higher learning; or
(D) Married.

(24) Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-2.020(1)(A)3. Dependent participation may be further defined to include the participating employee's:
(A) Spouse only;
(B) Child(ren) only; or
(C) Spouse and child(ren).

(25) Employee only participation. Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents.

(26) Employees. Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law.

(27) Employer. The state department that employs the eligible employee as defined above.

(28) Executive director. The administrator of the Missouri Consolidated Health Care Plan (MCHCP) who reports directly to the plan administrator.

(29) Experimental/Investigational/Unproven. A treatment, procedure, device or drug that meets any of the criteria listed below is considered experimental/investigational/unproven, and is not eligible for coverage under the plan. Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device or drug that the plan administrator determines, in the exercise of its discretion:
(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;
(B) Is shown by reliable evidence to be the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, safety, efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or
(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficiency as compared with the standard means of treatment or diagnosis.

(30) Formulary drugs. A list of drugs preferred by the claims administrator of the pharmacy program and as allowed by the plan administrator.

(31) Grievance. A written complaint submitted by or on behalf of a member regarding either:
(A) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or
(B) Claims payment, handling or reimbursement for health care services.

(32) Health maintenance organization (HMO). A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment.

(33) Home health agency. An agency certified by the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes.

(34) Hospice. A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.

(35) Hospital.
(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24) hour-a-day nursing service by a registered nurse (RN) on duty or call.
(B) An institution not meeting all the requirements of (35)(A) of this rule, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.
(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).
(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.
(E) A residential alcoholism, chemical dependency or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.
(F) In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home or facility for the aged.

(36) Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.

(37) Hospital room charges. The hospital's most common charge for semi-private accommodations, unless a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.

(38) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered as any other illness.

(39) Incident. A definite and separate occurrence of a condition.

(40) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

(41) Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice or free-standing chemical dependency treatment center.

(42) Legend. Any drug that requires a prescription from either a physician or a practitioner, under either federal or applicable state law, in order to be dispensed.

(43) Lifetime. The period of time you or your eligible dependents participate in the plan.

(44) Lifetime Maximum. The maximum amount payable by a medical plan during a covered member's life.

(45) Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.

(46) Medically necessary. Treatments, procedures, services or supplies that the plan administrator determines, in the exercise of its discretion:

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a health care provider has prescribed, ordered or recommended a treatment, procedure, service or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service or supply must not be specifically excluded from coverage under this plan.

(47) Network provider. A physician, hospital, pharmacy, etc., that is contracted with the medical plan.

(48) Non-formulary. A drug not contained on the health plan's or the pharmacy program's formulary list or preferred drug list.

(49) Non-network provider or non-participating provider. Any physician, hospital, pharmacy, etc., that does not have a contract with the health plan or the pharmacy program.

(50) Nurse. A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

(51) Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

(52) Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.

(53) Out-of-network. Providers that do not participate in the member's health plan.

(54) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

(55) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric nurses and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.

(56) Participant. Any employee or dependent accepted for membership in the plan.

(57) Pharmacy benefit manager (PBM). Acts as a link between the parties involved in the delivery of prescription drugs to health plan members. The PBM designs, implements, manages the overall drug benefit of the plan, and processes claims payments.

(58) Physically or mentally disabled. The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.

(59) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo.

(60) Plan. The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

(61) Plan administrator. The trustees of the Missouri Consolidated Health Care Plan. As such, the board is the sole fiduciary of the plan, has all discretionary authority to interpret its provisions and to control the operation and administration of the plan, and whose decisions are final and binding on all parties.

(62) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

(63) Plan year. Same as benefit year.

(64) Point-of-service (POS). A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized.

(65) Pre-admission testing. X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission.

(66) Pre-authorization. A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or

the plan. Without prior authorization, the plan may not pay for the test, drug, or service.

(67) Pre-certification program. Also known as pre-admission certification, pre-admission review, and pre-certification. The process of obtaining certification or authorization from the plan for routine hospital admissions and surgical or diagnostic procedures (inpatient or outpatient).

(68) Pre-existing condition. A condition for which you have incurred medical expenses or received treatment within the three (3) months prior to your effective date of coverage.

(69) Preferred provider organization (PPO). An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers.

(70) Prevailing fee. The fee charged by the majority of dentists.

(71) Primary care physician (PCP). A physician (usually an internist, family/general practitioner or pediatrician) who has contracted with and been approved by an HMO or POS. The PCP is accountable for all medical services of members including referrals. The PCP supervises other provided care such as services of specialists and hospitalization.

(72) Prior plan. The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP.

(73) Proof of insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

(74) Prostheses. An artificial extension that replaces a missing part of the body. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital) or to supplement defective parts.

(75) Provider. Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

(76) Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.

(77) Refractions. A record of the patient's preference for the focusing of the eyes that can then be used to purchase eyeglasses. It is the portion of the eye exam that determines what prescription lens provides the patient with the best possible vision.

(78) Rehabilitation facility. A legally operating institution or distinct part of an institution that has a transfer agreement with one or more hospitals and is primarily engaged in providing comprehensive multidisciplinary physical restorative services, post-acute hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse or tuberculosis, except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.

(79) Review agency. A company responsible for administration of clinical management programs.

(80) Second opinion program. A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.

(81) Skilled nursing facility (SNF). An institution which meets fully each of the following requirements:

(A) It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

(B) It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

(C) A skilled nursing facility shall be deemed to include institutions meeting the criteria in section (81) of this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97).

(82) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

(83) Specialty drugs. High cost drugs that are primarily self-injectible but sometimes oral medications.

(84) State. Missouri.

(85) Subrogation. The substitution of one "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the participant and recover the money directly from the other insurer.

(86) Subscriber. The employee or member who elects coverage under the plan.

(87) Survivor. A member who meets the requirements of 22 CSR 10-2.020(5)(A).

(88) Unemancipated child(ren). A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

(A) Stepchild(ren);

(B) Foster child(ren) for whom the employee is responsible for health care;

(C) Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;

(D) Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator.

1. Except for a disabled child(ren) as described in section (58) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or

attains age twenty-three (23) (see 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-three (23)); and

(E) Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan;

(89) Usual, customary, and reasonable charge.

(A) Usual. The fee a physician most frequently charges the majority of his/her patients for the same or similar services;

(B) Customary. The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

(C) Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported.

(90) Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

(91) Vested subscriber. A member who meets the requirements of 22 CSR 10-2.020(5)(B).

AUTHORITY: section 103.059, RSMo 2000. 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 and rule filed Dec. 22, 2005, effective Jan. 1, 2006, expires June 29, 2006. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions. The board is amending sections (2), (3) and (8).

PURPOSE: This amendment modifies the policy of the board of trustees in regard to the employee's subscriber agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2006, in accordance with the new plan year. Therefore, this amendment is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2006, in order that an immediate danger is not imposed on the public welfare. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 22, 2005, effective January 1, 2006, expires June 29, 2006.*

(2) The effective date of participation shall be determined, subject to the effective date provision in subsection (2)(C), as follows:

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation. Application for participants must be made in accordance with the following provisions. **Effective dates for all dependent coverage is wholly dependent upon paragraph (2)(B)1.**

1. Proof of eligibility documentation is required for all dependents. The plan 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 the plan administrator, coverage for the applicable dependent will either be terminated or will never take effect.

A. For the addition of dependents: Required documentation should accompany the application for coverage. Failure to provide acceptable documentation with the application will result in the dependent not having coverage until such proof is received, subject to the deadline noted in part (2)(B)1.A.(I).

(I) If proof of eligibility is not received with the application, such proof will be requested by letter sent to the subscriber. Documentation shall be received no later than thirty (30) days from the date of the letter requesting such proof. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period unless a life event occurs.

2. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death.

3. Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	• **Birth certificate; or** • **Hospital certificate**
Addition of step -child(ren)	• **Marriage license to biological parent of child(ren);** ***and*** • **Birth or Hospital certificate for child(ren) that names the subscriber's spou se as a parent**
Addition of foster -child(ren)	• **Placement papers in subscriber's care**
Adoption of dependent(s)	• **Adoption papers; or** • **Placement papers**
Legal guardianship of dependent(s)	• **Court-documented guardianship papers (Power of Attorney is not acceptable)**
Newborn of covered dependent	• **Birth certificate for subscriber's child(ren);** ***and*** • **Birth certificate for subscriber's grandchild(ren)**
Marriage	• **Marriage license;** • **Marriage certificate; or** • **Newspaper notice of the wedding**
Divorce	• **Final divorce decree; or** • **Notarized letter from spouse stating he/she is agreeable to termination of coverage pending divorce**
Death	• **Death Certificate**

4. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided.

*[1.]***5.** If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

*[2.]***6.** When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made;

*[3.]***7.** Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (2)(B)*[3.]***7.**A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and

*[4.]***8.** Survivors, retirees, vested subscribers and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage;

(C) Effective Date Proviso. **The effective date of coverage is the first of the month coinciding with or following your eligibility date and the date the form is received by the plan. The effective date of coverage cannot be prior to the date of receipt of the enrollment form by the plan. The effective date for dependent coverage is wholly dependent upon the appropriate proof of eligibility documentation being timely received by the plan (see (2)(B)1.).**

[1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work;]

(3) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (4) and (5).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule **or upon failure to provide the plan with acceptable proof of eligibility** with the following exception: unemancipated mentally retarded and/or physically handicapped children will continue to be eligible beyond age twenty-three (23) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-third birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (5).

(8) Medicare. Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, 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 was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; *[and]*

(B) If a participant eligible for Medicare Part D enrolls in a Medicare Part D plan in addition to coverage under this plan, such participant's coverage may be terminated under this plan in order for the plan to avoid liability for filing a false claim under the subsidy reimbursement portion of Medicare Part D; and

[(B)] **(C)** If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

*AUTHORITY: section 103.059, RSMo 2000. 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 Dec. 22, 2005, effective Jan. 1, 2006, expires June 29, 2006. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.050 PPO and Co-Pay Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the benefit provisions and covered charges in the Missouri Consolidated Health Care Plan PPO and/or Co-Pay plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2006, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2006, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and*

***United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 22, 2005, effective January 1, 2006, expires June 29, 2006.*

(1) Lifetime maximum, three (3) million dollars.

(2) Automatic annual reinstatement—maximum, five thousand dollars ($5,000).

(3) Deductible amount—per individual for the Preferred Provider Organization (PPO) plan each calendar year, five hundred dollars ($500), family limit each calendar year, one thousand dollars ($1,000).

(4) Coinsurance—non-network coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once out-of-pocket maximum is reached.

(A) The deductible is waived and claims are paid at eighty percent (80%) for the following services: home health care, infusion, durable medical equipment (DME), and audiologists.

(B) Claims may also be paid at eighty percent (80%) if you require covered services that are not available through a network provider in your area. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(C) Non-network claims—seventy percent (70%) of the first four thousand dollars ($4,000) for an individual, or of the first eight thousand dollars ($8,000) for a family, of covered charges in the calendar year which are subject to coinsurance. One hundred percent (100%) of any excess covered charges in the calendar year. But see the provision applicable to second opinion, substance abuse and mental and nervous conditions, chiropractic care and PPOs.

(5) Co-payments—set charges for the following types of claims so long as network providers are utilized. Co-payments are no longer charged for the remainder of the calendar year once out-of-pocket maximum is reached with the exceptions noted under (5)(G).

(A) Office visit—twenty-five dollars ($25).

(B) Laboratory and X-ray services—no co-payment; covered at one hundred percent (100%).

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission.

(D) Maternity—twenty-five dollars ($25) for initial visit.

(E) Preventive care—no co-payment; covered at one hundred percent (100%).

(F) Outpatient surgery—seventy-five dollars ($75).

(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: office visits, emergency room visits, hospital admissions, outpatient surgery, claims for services paid at one hundred percent (100%), charges above the Usual, Customary, and Reasonable (UCR) limit, percentage amount coinsurance is reduced as a result of non-compliance with pre-certification, coinsurance amounts related to infertility benefits, and charges above the maximum allowable amount for transplants performed by a non-network provider.

(6) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year. Certain co-payments do not apply to the out-of-pocket maximum as noted under 5(G).

(A) Network out-of-pocket maximum for individual—two thousand dollars ($2,000);

(B) Network out-of-pocket maximum for family—four thousand dollars ($4,000);

(C) Non-network out-of-pocket maximum for individual—four thousand dollars ($4,000);

(D) Non-network out-of-pocket maximum for family—eight thousand dollars ($8,000);

(7) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. 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 rule filed Dec. 22, 2005, effective Jan. 1, 2006, expires June 29, 2006. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2— State Membership

EMERGENCY RULE

22 CSR 10-2.060 PPO and Co-Pay Plan Limitations

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO and/or Co-Pay plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2006, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2006, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 22, 2005, effective January 1, 2006, expires June 29, 2006.*

(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, or within any of the sections of this rule.

(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency or mental and nervous disorder that are not precertified as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.

(3) Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(4) Allergy services—no coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy.

(6) Autopsy.

(7) Blood storage, including whole blood, blood plasma and blood products.

(8) Care received without charge.

(9) Comfort and convenience items.

(10) Cosmetic, plastic, reconstructive or restorative surgery—unless medically necessary to repair a functional disorder caused by disease, injury or congenital defect or abnormality (for a participant under the age of nineteen (19)) or to restore symmetry following a mastectomy.

(11) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered.

(12) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound natural teeth. Oral surgery is covered only when medically necessary as a direct result from injury, tumors or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

(13) Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

(14) Educational or psychological testing— not covered unless part of a treatment program for covered services.

(15) Examinations requested by a third party.

(16) Exercise Equipment.

(17) Experimental services or investigational services—experimental or investigational services, procedures, supplies or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

(18) Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

(19) Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK and other refractive eye surgery.

(20) Services obtained at a government facility—not covered if care is provided without charge.

(21) Hair analysis, wigs and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces and hair prostheses, including those ordered by a participating provider are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar ($200) annual maximum and three thousand two hundred dollar ($3,200) lifetime maximum.

(22) Health and athletic club membership—including costs of enrollment.

(23) Immunizations requested by third party or for travel.

(24) Infertility—not covered. Those health services and associated expenses for the treatment of infertility including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), in vitro fertilization, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and nonmedically necessary amniocentesis.

(25) Level of care, if greater than is needed for the treatment of the illness or injury.

(26) Medical care and supplies—not to the extent that they are payable under—

(A) A plan or program operated by a national government or one of its agencies; or

(B) Any state's cash sickness or similar law including any group insurance policy approved under such law.

(27) Medical service performed by a family member—including a person who ordinarily resides in your household or is related to the participant, such as a spouse, parent, child, sibling or brother/sister-in-law.

(28) Military service connected injury or illness.

(29) Non-network providers—subject to deductible and non-network coinsurance.

(30) Not medically necessary services—with the exception of preventive services.

(31) Obesity—medical and surgical intervention is not covered.

(32) Orthognathic surgery.

(33) Orthoptics.

(34) Other charges—no coverage for charges that would not be incurred if you were not covered. Charges for which you or your dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in your name but which are actually due to the injury or illness of a different person not covered by the plan.

(35) Over-the-counter medications—except for insulin through the pharmacy benefit.

(36) Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings and support hose.

(37) Physical fitness.

(38) Pre-existing conditions—not covered for charges associated with pre-existing conditions.

(39) Private duty nursing.

(40) Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related or medically necessary.

(41) Services not specifically included as benefits.

(42) Smoking cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.

(43) Stimulators (for bone growth)—not covered unless authorized by claims administrator.

(44) Surrogacy—pregnancy coverage is limited to plan member.

(45) Temporo-Mandibular Joint Syndrome (TMJ).

(46) Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.

(47) Travel expenses—not covered unless authorized by claims administrator.

(48) Trimming of nails, corns or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease or blindness.

(49) Usual, customary and reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

(50) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions and hematopoietic agents through the pharmacy benefit.

(51) War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot or other circumstances beyond the control of the plan.

(52) Workers' compensation—charges for services and treatment of an injury incurred during the course of employment and covered by Workers' Compensation, occupational disease law or similar laws, including all charges to be covered by any associated settlement agreement.

*AUTHORITY: section 103.059, RSMo 2000. 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 rule filed Dec. 22, 2005, effective Jan. 1, 2006, expires June 29, 2006. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.064 HMO and POS Summary of Medical Benefits

PURPOSE: This rule establishes the benefit provisions and covered charges in the Missouri Consolidated Health Care Plan HMO and POS plans.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2006, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2006, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 22, 2005, effective January 1, 2006, expires June 29, 2006.*

(1) Co-payments—set charges for the following types of claims so long as network providers are utilized.
(A) Office visit—twenty-five dollars ($25).
(B) Laboratory and X-ray services—no co-payment; covered at one hundred percent (100%).
(C) Inpatient hospitalizations—three hundred dollars ($300) per admission.
(D) Maternity—twenty-five dollars ($25) for initial visit.
(E) Preventive care—no co-payment; covered at one hundred percent (100%).
(F) Outpatient surgery—seventy-five dollars ($75).

(2) Out-of-pocket maximum—Limited to no more than fifty percent (50%) of the cost of providing a single service. Co-payments are limited to no more than twenty percent (20%) of the cost of providing basic health care services for the total benefit period and may not exceed two hundred percent (200%) of the total annual premium.

(3) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. 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 rule filed Dec. 22, 2005, effective Jan. 1, 2006, expires June 29, 2006. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.067 HMO and POS Limitations

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan HMO and/or POS plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2006, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2006, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 22, 2005, effective January 1, 2006, expires June 29, 2006.*

(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, or within any of the sections of this rule.

(2) If applicable, all hospitalizations, outpatient treatment for chemical dependency or mental and nervous disorder that are not precertified as described in 22 CSR 10-2.045, reimbursement will be reduced by ten percent (10%) of reasonable and customary charges.

(3) Abortion—other than situations where the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(4) Allergy services—no coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy.

(6) Autopsy.

(7) Blood storage, including whole blood, blood plasma and blood products.

(8) Care received without charge.

(9) Comfort and convenience items.

(10) Cosmetic, plastic, reconstructive or restorative surgery—unless medically necessary to repair a functional disorder caused by disease, injury or congenital defect or abnormality (for a participant under the age of nineteen (19)) or to restore symmetry following a mastectomy.

(11) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered.

(12) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound natural teeth. Oral surgery is covered only when medically necessary as a direct result from injury, tumors or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.

(13) Durable medical equipment and disposable supplies—nonreusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.

(14) Educational or psychological testing—not covered unless part of a treatment program for covered services.

(15) Examinations requested by a third party.

(16) Exercise equipment.

(17) Experimental services or investigational services—experimental or investigational services, procedures, supplies or drugs as determined by the claims administrator are not covered, except clinical trials for cancer treatment as specified by law.

(18) Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.

(19) Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK and other refractive eye surgery.

(20) Services obtained at a government facility—not covered if care is provided without charge.

(21) Hair analysis, wigs and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces and hair prostheses, including those ordered by a participating provider are not covered. Such items and services are not covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar ($200) annual maximum and three thousand two hundred dollar ($3,200) lifetime maximum.

(22) Health and athletic club membership—including costs of enrollment.

(23) Immunizations requested by third party or for travel.

(24) Infertility—Not covered. Those health services and associated expenses for the treatment of infertility including reversal of voluntary sterilization, intracytoplasmic sperm injection (ICSI), in vitro fertilization, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; donor sperm and related cost for collection; no cryopreservation of sperm or eggs; and nonmedically necessary amniocentesis.

(25) Level of care, if greater than is needed for the treatment of the illness or injury.

(26) Medical care and supplies—not to the extent that they are payable under—

(A) A plan or program operated by a national government or one of its agencies; or

(B) Any state's cash sickness or similar law including any group insurance policy approved under such law.

(27) Medical service performed by a family member—including a person who ordinarily resides in your household or is related to the participant, such as a spouse, parent, child, sibling or brother/sister-in-law.

(28) Military service connected injury or illness.

(29) Non-network providers—not covered unless in case of emergency or with prior approval of claims administrator.

(30) Not medically necessary services—with the exception of preventive services.

(31) Obesity—Medical and surgical intervention is not covered.

(32) Orthognathic surgery.

(33) Orthoptics.

(34) Other charges—no coverage for charges that would not be incurred if you were not covered. Charges for which you or your dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in your name but which are actually due to the injury or illness of a different person not covered by the plan.

(35) Over-the-counter medications—except for insulin through the pharmacy benefit.

(36) Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings and support hose.

(37) Physical fitness.

(38) Pre-existing conditions—not applicable to health maintenance organization (HMO) coverage.

(39) Private duty nursing.

(40) Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related or medically necessary.

(41) Services not specifically included as benefits.

(42) Smoking cessation—patches and gum are not covered. There is a limited benefit available under the pharmacy benefit.

(43) Stimulators (for bone growth)—not covered unless authorized by claims administrator.

(44) Surrogacy—pregnancy coverage is limited to plan member.

(45) Temporo-Mandibular Joint Syndrome (TMJ).

(46) Transsexual surgery—health services and associated expenses in the transformation operations regardless of any diagnosis or gender role disorientation or psychosexual orientation or any treatment or studies related to sex transformation. Also excludes hormonal support for sex transformation.

(47) Travel expenses—not covered unless authorized by claims administrator.

(48) Trimming of nails, corns or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease or blindness.

(49) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions and hematopoietic agents through the pharmacy benefit.

(50) War or insurrection—liability to provide services limited in the event of a major disaster, epidemic, riot or other circumstances beyond the control of the plan.

(51) Workers' compensation—charges for services and treatment of an injury incurred during the course of employment and covered by Workers' Compensation, occupational disease law or similar laws, including all charges to be covered by any associated settlement agreement.

*AUTHORITY: section 103.059, RSMo 2000. 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 rule filed Dec. 22, 2005, effective Jan. 1, 2006, expires June 29, 2006. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the benefit provisions, covered charges, limitations and exclusions of the Missouri Consolidated Health Care Plan pharmacy benefit.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2006, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2006, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 22, 2005, effective January 1, 2006, expires June 29, 2006.*

(1) The pharmacy benefit provides coverage for prescription drugs, as described in the following:

(A) Medications.

1. In-network:

A. Generic: Ten dollar ($10) co-payment for thirty (30)-day supply for generic drug on the formulary;

B. Formulary brand: Thirty dollar ($30) co-payment for thirty (30)-day supply for brand drug on the formulary;

C. Non-formulary: Fifty dollar ($50) co-payment for thirty (30)-day supply for non-formulary drug;

D. Prescriptions filled with a formulary brand drug when a generic is available will be subject to the generic co-payment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;

E. Mail order program—Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for twice the regular co-payment.

2. Non-network pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the pharmacy plan administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable co-payment. Any difference between the amount paid by the member at a non-network pharmacy and the amount that would have been allowed at an in-network pharmacy will not be applied to any out-of-pocket maximum. All such claims must be filed within twelve (12) months of the incurred expense.

(2) If the co-payment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the co-payment.

(3) Retail and mail order coverage includes the following:

(A) Diabetic supplies, including:

1. Insulin;
2. Syringes:
3. Test strips;
4. Lancets; and
5. Glucometers;

(B) Prescribed vitamins, excluding those vitamins that may be purchased over-the-counter;

(C) Prescribed self-injectables;

(D) Oral chemotherapy agents;

(E) Hematopoietic stimulants;

(F) Growth hormones with prior authorization;

(G) Infertility drugs—subject to fifty percent (50%) member coinsurance; and

(H) Smoking cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar ($500) annual benefit. Patches or gum are not covered.

(4) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable co-payment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.

(A) First Step:

1. Uses primarily generic drugs;
2. Lowest applicable co-payment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

(B) Second Step:

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand name drugs; and
3. Typically, a higher co-payment amount is applicable.

(5) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.

(6) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must:

(A) Complete the claim form;

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable, but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include:

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days supply.

(7) Formulary—The formulary does not change during a calendar year, unless:

(A) A generic drug becomes available to replace the brand name drug. If this occurs, the generic co-payment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expires June 29, 2006. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2005.

EXECUTIVE ORDER
05-46

WHEREAS, reliable and affordable energy is essential to the health and welfare of Missouri citizens; and

WHEREAS, reliable and affordable energy is also essential to the economic well being of this State; and

WHEREAS, the State of Missouri needs a long-term comprehensive approach to assuring an adequate and reasonably priced energy supply; and

WHEREAS, new opportunities for alternative fuel sources and agriculturally based fuels should be promoted to lessen the State's dependence on foreign oil and gas.

NOW THEREFORE, I, Matt Blunt, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and Laws of the State of Missouri, do hereby create and establish the Missouri Energy Task Force.

The Task Force shall be composed of nine members. The Chair of the Public Service Commission shall serve as chairman of the Task Force and the remaining positions shall be filled by the following individuals:

a. The Lieutenant Governor, in his capacity as Senior Advocate for Missouri;

b. The Public Counsel;

c. The Speaker of the House of Representatives;

d. The President Pro Tem of the Senate;

e. One member of the House of Representatives' Utilities Committee, as designated by the Speaker;

f. One member of the Senate's Commerce and Environment Committee, as designated by the President Pro Tem;

g. The Director of the Department of Agriculture, or his designee; and

h. The Director of the Department of Natural Resources, or his designee.

Members of the Task Force shall receive no compensation for their service to the people of Missouri but may seek reimbursement for their reasonable and necessary expenses incurred as members of the Task Force, in accordance with the rules and regulations of the Office of Administration, to the extent that funds are available for such purpose.

The Task Force is assigned for administrative purposes to the Public Service Commission. The Executive Director of the Public Service Commission shall be available to assist the Task Force as necessary, and shall provide the Task Force with any staff assistance the Task Force may require from time to time.

The Task Force shall meet at the call of its Chair, and the Chair shall call the first meeting of the Task Force as soon as possible.

The Task Force shall provide a final report to the Governor no later than August 31, 2006. This report shall provide specific recommendations to:

1. Lessen Missouri's dependence on oil and other fossil fuels;

2. Assist Missourians who need help to afford their winter heating bills;

3. Promote the development of alternative fuel sources in ways that strengthen the farm economy of rural Missouri;

4. Encourage Missouri utilities to develop and operate electric power generation resources that will provide low-cost electricity well into the future.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 27th day of December, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State