Volume 35, Number 3
Pages 157–346
February 1, 2010

SALUS POPULI SUPREMA LEX ESTO

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

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

Secretary of State

Robin Carnahan

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO

Subscription fee: $56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER
Office of the Secretary of State
Administrative Rules Division
PO Box 1767
Jefferson City, MO 65102

The *Missouri Register* and *Code of State Regulations* (CSR) are now available on the Internet. The Register address is http://www.sos.mo.gov/adrules/moreg/moreg.asp and the CSR is http://www.sos.mo.gov/adrules/csr/csr.asp. These websites contain rulemakings and regulations as they appear in the Registers and CSR. These websites do not contain the official copies of the Registers and CSR. The official copies remain the paper copies published by the Office of the Secretary of State pursuant to sections 536.015 and 536.031, RSMo Supp. 2009. While every attempt has been made to ensure accuracy and reliability, the Registers and CSR are presented, to the greatest extent practicable as they appear in the official publications. The Administrative Rules Division may be contacted by email at rules@sos.mo.gov.

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.

MISSOURI REGISTER

February 1, 2010 Vol. 35 No. 3 **Pages 157–346**

IN THIS ISSUE:

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
October 1, 2009	**November 2, 2009**	November 30, 2009	December 30, 2009
October 15, 2009	**November 16, 2009**	November 30, 2009	December 30, 2009
November 2, 2009	**December 1, 2009**	December 31, 2009	January 30, 2010
November 16, 2009	**December 15, 2009**	December 31, 2009	January 30, 2010
December 1, 2009	**January 4, 2010**	January 29, 2010	February 28, 2010
December 15, 2009	**January 15, 2010**	January 29, 2010	February 28, 2010
January 4, 2010	**February 1, 2010**	February 28, 2010	March 30, 2010
January 15, 2010	**February 16, 2010**	February 28, 2010	March 30, 2010
February 1, 2010	**March 1, 2010**	March 31, 2010	April 30, 2010
February 16, 2010	**March 15, 2010**	March 31, 2010	April 30, 2010
March 1, 2010	**April 1, 2010**	April 30, 2010	May 30, 2010
March 15, 2010	**April 15, 2010**	April 30, 2010	May 30, 2010
April 1, 2010	**May 3, 2010**	May 31, 2010	June 30, 2010
April 15, 2010	**May 17, 2010**	May 31, 2010	June 30, 2010
May 3, 2010	**June 1, 2010**	June 30, 2010	July 30, 2010
May 17, 2010	**June 15, 2010**	June 30, 2010	July 30, 2010
June 1, 2010	**July 1, 2010**	July 31, 2010	August 30, 2010
June 15, 2010	**July 15, 2010**	July 31, 2010	August 30, 2010

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

Missouri Participating Libraries

The *Missouri Register* and the *Code of State Regulations*, as required by the Missouri Documents Law (section 181.100, RSMo Supp. 2009), are available in the listed participating libraries, as selected by the Missouri State Library:

Jefferson County Library
PO Box 1486, 3021 High Ridge
High Ridge, MO 63049-1486
(314) 677-8689

Jefferson College Library
1000 Viking Drive
Hillsboro, MO 63050-2441
(314) 789-3951 ext. 160

St. Louis Public Library
1301 Olive St.
St. Louis, MO 63103-2389
(314) 539-0376

St. Louis University Law Library
3700 Lindell Blvd.
St. Louis, MO 63108-3478
(314) 977-2742

Eden/Webster Library
Eden Theological Seminary/
Webster University
475 East Lockwood Ave.
St. Louis, MO 63119-3192
(314) 961-2660 ext. 7812

Thomas Jefferson Library
University of Missouri-St. Louis
8001 Natural Bridge Road
St. Louis, MO 63121-4499
(314) 516-5084

Washington University Law Library
Washington University
Campus Box 1171, Mudd Bldg.,
One Brookings Dr.
St. Louis, MO 63130-4899
(314) 935-6443

St. Louis County Library
1640 S. Lindbergh Blvd.
St. Louis, MO 63131-3598
(314) 994-3300 ext. 247

Library
Maryville University
13550 Conway Road
St. Louis, MO 63141-7232
(314) 529-9494

Pickler Memorial Library
Truman State University
100 E. Normal
Kirksville, MO 63501-4221
(660) 785-7416

Learning Resources Center
Mineral Area College
PO Box 1000
Park Hills, MO 63601-1000
(573) 431-4593

Cape Girardeau Public Library
711 N. Clark
Cape Girardeau, MO 63701-4400
(573) 334-5279

Kent Library
Southeast Missouri State University
One University Plaza
Cape Girardeau, MO 63701-4799
(573) 651-2757

Riverside Regional Library
PO Box 389, 204 South Union St.
Jackson, MO 63755-0389
(573) 243-8141

Rutland Library
Three Rivers Community College
2080 Three Rivers Blvd.
Poplar Bluff, MO 63901-2393
(573) 840-9656

James C. Kirkpatrick Library
University of Central Missouri
142 Edwards Library
Warrensburg, MO 64093-5020
(660) 543-4149

Kansas City Public Library
14 West 10th Street
Kansas City, MO 64105
(816) 701-3546

Law Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

Miller Nichols Library
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499
(816) 235-2438

B.D. Owens Library
Northwest Missouri State University
800 University Drive
Maryville, MO 64468-6001
(660) 562-1841

St. Joseph Public Library
927 Felix Street
St. Joseph, MO 64501-2799
(816) 232-8151

Hearnes Learning Resources Ctr.
Missouri Western State University
4525 Downs Drive
St. Joseph, MO 64507-2294
(816) 271-5802

Library
North Central Missouri College
PO Box 111, 1301 Main Street
Trenton, MO 64683-0107
(660) 359-3948 ext. 325

Spiva Library
Missouri Southern State University
3950 East Newman Road
Joplin, MO 64801-1595
(417) 625-9342

Missouri State Library
600 West Main, PO Box 387
Jefferson City, MO 65102-0387
(573) 751-3615

Missouri State Archives
600 West Main, PO Box 778
Jefferson City, MO 65102-0778
(573) 526-6711

Elmer Ellis Library
University of Missouri-Columbia
106 B Ellis Library
Columbia, MO 65211-5149
(573) 882-0748

Library
State Historical Society of Missouri
1020 Lowry St.
Columbia, MO 65211-7298
(573) 882-9369

Daniel Boone Regional Library
PO Box 1267, 100 West Broadway
Columbia, MO 65205-1267
(573) 443-3161 ext. 359

School of Law
University of Missouri-Columbia
224 Hulston Hall
Columbia, MO 65211-0001
(573) 882-1125

Smiley Memorial Library
Central Methodist University
411 Central Methodist Square
Fayette, MO 65248-1198
(660) 248-6279

Library
Missouri University of Science and
Technology
1870 Miner Circle
Rolla, MO 65409-0060
(573) 341-4007

Lebanon-Laclede County Library
135 Harwood Ave.
Lebanon, MO 65536-3017
(417) 532-2148

University Library
Southwest Baptist University
1600 University Ave.
Bolivar, MO 65613-2597
(417) 328-1631

Barry-Lawrence Regional Library
213 6th St.
Monett, MO 65708-2147
(417) 235-6646

Lyons Memorial Library
College of the Ozarks
General Delivery
Point Lookout, MO 65726-9999
(417) 334-6411 ext. 3551

Garnett Library
Missouri State University—West
Plains
304 Cleveland
West Plains, MO 65775-3414
(417) 255-7945

Springfield-Greene County Library
4653 S. Campbell
Springfield, MO 65801-0760
(417) 874-8110

Meyer Library
Missouri State University
PO Box 175, 901 S. National
Springfield, MO 65804-0095
(417) 836-4533

HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

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 6—DEPARTMENT OF HIGHER EDUCATION
Division 250—University of Missouri
Chapter 11—Administration of Missouri Fertilizer Law

EMERGENCY RULE

6 CSR 250-11.041 Inspection Fee on Manipulated Animal or Vegetable Manure Fertilizers

PURPOSE: This rule establishes the inspection fee on manipulated animal or vegetable manure fertilizers sold in the state.

EMERGENCY STATEMENT: This emergency rule informs state agencies and the public that a new fee structure for manipulated manure fertilizers has been implemented by the Missouri Legislature. This emergency rule is necessary because of new statute language adopted on May 15, 2009, and signed on July 7, 2009, that went into force on August 28, 2009. There is a default fee of thirty cents (30¢) per ton written into section 266.331, RSMo, for fertilizer classifications on which rules have not been developed which could cause distributors of these types of products to pay higher fees than the legislature has imposed. A proposed rule has been filed; however, it will not go into effect until after the next fee is required to be paid by the distributors which could result in higher fees or penalties to those distributors. A proposed rule, which covers the same material, was published in the ***Missouri Register*** *on December 15, 2009 (34 MoReg 2592–2593). The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Missouri Agricultural Experiment Station believes this emergency rule is fair to all interested persons and parties under the circumstances. This emergency rule was filed on December 22, 2009, becomes effective January 1, 2010, and expires June 28, 2010.*

(1) The fee provided to be established by rule under section 266.331, RSMo, for manipulated animal or vegetable manure fertilizers. Manipulated manure fertilizers shall be guaranteed. The fee established at two cents (2¢) per ton per percent nitrogen for nitrogen levels less than five percent (5%), four cents (4¢) per ton per percent nitrogen for nitrogen levels of five percent (5%) but less than ten percent (10%), or six cents (6¢) per ton per percent nitrogen for nitrogen levels of ten percent (10%) or greater.

AUTHORITY: section 266.331, HB 734, Ninety-fifth General Assembly 2009. Original rule filed Nov. 13, 2009. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 28, 2010.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending sections (3), (15), (16), and (18).

PURPOSE: This amendment provides for the State Fiscal Year (SFY) 2010 trend factor, revises the better of days calculation for all hospitals, revises the utilization adjustment for all hospitals except for safety net hospitals, clarifies disproportionate share hospital (DSH) calculation to allow for payment up to one hundred percent (100%) of DSH allotment, and defines DSH cap.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division by rule and regulation must define the reasonable costs, manner, extent, quantity, quality, charges, and fees of medical assistance. Due to the growing obligations on the Federal Reimbursement Allowance (FRA) Fund and the limited FRA resources, the FRA Fund balance has been deteriorating. A review of the payment calculations that obligate the FRA Fund was necessary to sustain a reasonable balance in the fund so that hospital payments could continue to be made. The MO HealthNet Division (MHD) has been reviewing its hospital Direct Medicaid payments including the manner for estimating Medicaid patient days, which uses a better of days methodology. The most notable finding was the excess Medicaid patient days estimated for some Missouri hospitals, as the estimated days simply have not materialized. MHD determined that the better of days methodology needed to be phased out so that the estimated days were more in line with actual days. This emergency amendment establishes the calculation of the Direct Medicaid payments effective for dates of service beginning January 1, 2010, to ensure that quality health care continues to be provided to MO HealthNet participants at hospitals that have relied on MO HealthNet payments to meet those patients' needs. This emergency amendment will ensure payment to Missouri hospitals providing health care to over eight hundred sixty thousand (860,000) Missourians eligible for the MO HealthNet program plus the uninsured. The MO HealthNet Division finds an immediate danger to public health, safety, and/or welfare and a compelling governmental interest which requires emergency action. The MO HealthNet program has a compelling government interest in providing continued cash flow for inpatient hospital services. The scope of this emergency amendment is limited to the circumstances creating the

*emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The MO HealthNet Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. A proposed amendment covering this same material was published in the **Missouri Register** on September 1, 2009 (34 MoReg 1802–1805). The final order of rulemaking relating to that proposed amendment includes changes as a result of comments received on the proposed amendment and was filed with the Joint Committee on Administrative Rules on November 25, 2009, and will be filed with the secretary of state December 28, 2009. Therefore, the division believes this emergency to be fair to all interested persons and parties under the circumstances. This emergency amendment was filed December 18, 2009, becomes effective January 1, 2010, and expires June 29, 2010.*

(3) Per Diem Reimbursement Rate Computation. Each hospital shall receive a MO HealthNet per diem rate based on the following computation.

(B) Trend Indices (TI). Trend indices are determined based on the four (4)-quarter average DRI Index for DRI-Type Hospital Market Basket as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY).

1. The TI are—
   A. SFY 1994—4.6%
   B. SFY 1995—4.45%
   C. SFY 1996—4.575%
   D. SFY 1997—4.05%
   E. SFY 1998—3.1%
   F. SFY 1999—3.8%
   G. SFY 2000—4.0%
   H. SFY 2001—4.6%
   I. SFY 2002—4.8%
   J. SFY 2003—5.0%
   K. SFY 2004—6.2%
   L. SFY 2005—6.7%
   M. SFY 2006—5.7%
   N. SFY 2007—5.9%
   O. SFY 2008—5.5%
   P. SFY 2009—5.5%
   Q. SFY 2010—3.9%

2. The TI for SFY 1996 through SFY 1998 are applied as a full percentage to the OC of the per diem rate and for SFY 1999 the OC of the June 30, 1998**,** rate shall be trended by 1.2% and for SFY 2000 the OC of the June 30, 1999**,** rate shall be trended by 2.4%. The OC of the June 30, 2000**,** rate shall be trended by 1.95% for SFY 2001.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with subsection (15)(B).

(15) Direct Medicaid Payments.

(B) Direct Medicaid payment will be computed as follows:

1. The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital's base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment;

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The estimated MO HealthNet patient days for the current SFY shall be the better of the sum of the Fee-for-Service (FFS) days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective January 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2010, prior SFY would be SFY 2009) adjusted downward by twenty-five percent (25%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as follows: The FFS days are determined by applying a trend to the second prior Calendar Year (CY) days (i.e., for SFY 2010, second prior CY would be 2008) as determined from the state's Medicaid Management Information System (MMIS). The trend is determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by twenty-five percent (25%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by twenty-five percent (25%), and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

B. Effective July 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2011, prior SFY would be SFY 2010) adjusted downward by fifty percent (50%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by fifty percent (50%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part

(15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by fifty percent (50%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

C. Effective July 1, 2011, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2012, prior SFY would be SFY 2011) adjusted downward by seventy-five percent (75%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by seventy-five percent (75%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

D. Effective July 1, 2012, the estimated MO HealthNet patient days shall be the sum of the FFS days plus managed care days. The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

*[A.]***E.** The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A). In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of MO HealthNet residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospital's base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend, and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

*[B.]***F.** For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2., and (6)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year operating costs may be the third or fourth prior year cost report. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve (12)-month cost report and a partial year cost report, its base period cost report for that year will be the twelve (12)-month cost report.

*[C.]***G.** The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated MO HealthNet days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective January 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B) will receive sixty-seven percent (67%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

B. Effective July 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P) will receive thirty-four percent (34%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Children's hospitals and specialty pediatric hospitals will receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

C. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.;

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Prior to July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

(16) Safety Net Adjustment. A safety net adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph (6)(A)4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

(A) The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.B. or (6)(A)4.C. of this regulation shall be computed in accordance with the Direct Medicaid Payment calculation described in section (15) and the uninsured costs calculation described in subsection (18)(D) of this regulation. *[The safety net adjustment for the facilities that qualify under this subsection shall be calculated by adding an additional ten percent (10%) to the percentage that will be used to distribute either the total annual projected cost of the uninsured population that is related to hospital services, or the DSH cap for hospitals, whichever is lower (i.e., if ninety percent (90%) is*

used to distribute the annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals, whichever is lower, then one hundred percent (100%) would be used for the facilities that qualify under this subsection).] The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

(18) In accordance with state and federal laws regarding reimbursement of unreimbursed costs and the costs of services provided to uninsured patients, reimbursement for each State Fiscal Year (SFY) (July 1–June 30) shall be determined as follows:

(E) Uninsured Add-Ons effective July 1, 2009, for all facilities except Department of Mental Health (DMH) safety net facilities as defined in subparagraph (6)(A)4.D. DMH safety net facilities will continue to be calculated in accordance with subsection (18)(B). The Uninsured Add-On for all facilities except DMH safety net facilities will be based on the following:

1. Determination of the cost of the uninsured:

A. Allocate the uninsured population as determined from the Current Population Survey (CPS), Annual Social and Economic Supplement (Table HI05) as published by the U.S. Census Bureau, to the same categories of age (COA) and age groups as the managed care rate cells as determined by the Managed Care Unit of the MO HealthNet Division;

B. Determine the total annual projected cost of the uninsured population by multiplying the number of uninsured for each rate cell by the average contract per member per month (PMPM) for that individual managed care rate cell multiplied by twelve (12); and

C. Determine the amount of the total annual projected cost of the uninsured population that is related to hospital services by multiplying the total annual projected cost of the uninsured population as calculated in paragraph (18)(E)1. above by the percentage of the contract PMPM for each individual rate cell that is related to hospital services. This would be the maximum amount of uninsured add-on payments that could be made to hospitals. This amount is also subject to the DSH cap;

2. Proration to individual hospitals of the cost of the uninsured calculated in paragraph (18)(E)1.—

A. Determine each individual hospital's Uninsured Add-On payment by dividing the individual hospital's uninsured cost as determined from the three (3)-year average of the fourth, fifth, and sixth prior base year cost reports by the total uninsured cost for all hospitals as determined from the three (3)-year average of the fourth, fifth, and sixth prior base year cost reports, multiplied by either the total annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals, whichever is lower. The DSH cap for hospitals is the federal DSH allotment less the IMD allotment less any redirections of DSH for Medicaid coverage of uninsured individuals as authorized by appropriation; and

B. Hospitals which qualify as safety net hospitals under subparagraphs (6)(A)4.B. and (6)(A)4.C. shall receive payment up to one hundred percent (100%) of their proration. The percentage of proration payable to non-safety net hospitals shall be up to ninety-nine percent (99%), unless the hospital contributes through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative, in which case they shall receive up to one hundred percent (100%); and

3. For new hospitals that do not have a base year cost report, uninsured payments shall be estimated as follows:

A. Hospitals receiving uninsured payments shall be divided into quartiles based on total beds;

B. Uninsured payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average uninsured payment per bed; and

C. The numbers of beds for the new hospital without the base year cost report shall be multiplied by the average uninsured payment per bed.

*[(E)]***(F)** Uninsured Add-On payments will coincide with the semimonthly claim payment schedule established by the MO HealthNet fiscal agent. Each hospital's semimonthly add-on payment shall by the hospital's total cost of the uninsured as determined in *[sub]*section (18)*[(D),]* divided by the number of semimonthly pay dates available to the hospital in the state fiscal year.

*AUTHORITY: sections 208.152, 208.153, 208.201, and 208.471, RSMo Supp. [2007] **2008**. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Aug. 3, 2009. Emergency amendment filed Dec. 18, 2009, effective Jan. 1, 2010, expires June 29, 2010.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is deleting sections (2), (7), (8), (10), (64), (66), (79), and (81); renumbering and amending sections (3)–(6), (9), (11)–(63), (65), (67)–(78), (80), and (82)–(92); and adding new sections (6), (9)–(12), (14)–(18), (20), (24), (30), (34), (35), (41), (43), (45)–(47), (49), (50), (53), (59), (60), (64), (69), (70), (72), (76), (80), (82), (83), (99), (101), (102), (104), (106), (108)–(110), (114), (116), (119), (122), (125)–(127), and (130).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or

expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

[(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)]***(2)** Administrative appeal. *[Appeal procedures]* **A written request submitted by or on behalf of a member** involving Missouri Consolidated Health Care Plan (MCHCP) administrative issues such as eligibility, effective date**s** of coverage, **plan changes,** etc.

*[(4)]***(3)** Administrative guidelines. *[The]* **Instructive** 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)]***(4)** 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)]***(5)** 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.]

(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.

(7) Benefit period. The three hundred sixty-five (365) days immediately following the first date of like services.

*[(9)]***(8)** 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.]

(9) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

(10) Board. The board of trustees of the Missouri Consolidated Health Care Plan.

(11) Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

(12) Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(11)]***(13)** 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.

(14) Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

(15) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses such as deductible or coinsurance.

(16) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

(17) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.

(18) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

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

(20) Copayment. A set dollar amount that the covered individual must pay for specific services.

*[(13)]***(21)** 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)]***(22)** Covered benefits **and charges**. 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)]***(23)** 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]*

and require the continuing attention of trained medical or paramedical personnel.

(24) Date of service. Date medical services are received or performed.

*[(16)]***(25)** 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)]***(26)** Dependent-only participation. Participation of certain survivors of *[employees]* **subscribers**. Dependent participation may be further defined to include the deceased *[employee's]* **subscriber's**:
(A) Spouse only;
(B) Child(ren) only; or
(C) Spouse and child(ren).

*[(18)]***(27)** 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)]***(28)** Diagnostic charges. The Usual, Customary**,** and Reasonable (UCR) charges 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)]***(29)** Disposable supplies. **Medical supplies that** *[D]***d**o not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

(30) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:
(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental surgery; or
(H) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practice of spiritual healing are well established and recognized.

*[(21)]***(31)** 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)]***(32)** 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]* **are** eligible for participation *[subject to any applicable pre-existing conditions as outlined in the plan document]* **immediately**.
(C) Employees who terminate all employment with the state (not simply move from one **(1)** 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 **(1)** 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 **or at the employee's choice, on the first day of the month following the employee's date of rehire**.

*[(23)]***(33)** 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.

(34) Emergency. Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:
(A) Conditions placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) Situations when the health of a pregnant woman or her unborn child are threatened.

(35) Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

*[(24)]***(36)** 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)]***(37)** Employees. Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law.

*[(27)]***(38)** Employer. The state department **or agency** that employs the eligible employee as defined above.

*[(28)]***(39)** Executive director. The *[administrator]* **chief executive officer** of the Missouri Consolidated Health Care Plan (MCHCP) who *[reports directly to the plan administrator]* **shall have charge of the offices, records, and employees of the plan, subject to the direction of the board**.

*[(29)]***(40)** 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 clinical trials or under study to determine its maximum tolerated dose, its toxicity, **its** safety, **its** 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.

(41) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date the dependent meets the eligibility requirements for coverage under the plan.

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

(43) Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

*[(31)]***(44)** 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.

(45) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

(46) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference will be made available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook (January 1, 2010). It does not include any later amendments or additions.

(47) Health assessment. A questionnaire about a member's health and lifestyle habits which qualifies the member for participation in the *Lifestyle Ladder* program to earn the incentive premium.

*[(32)]***(48)** 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.

(49) Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

(50) High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

*[(33)]***(51)** Home health agency. An agency certified by **Medicare and** 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)]***(52)** Hospice. *[A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.]* **A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.**

(53) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

*[(35)]***(54)** 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)]***(54)**(A) *[of this rule]* **above**, 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)]***(55)** Hospital copayment. Set dollar amount a subscriber must pay for each hospital admission.

*[(37)]***(56)** Hospital room charges. The hospital's most common charge for semi-private accommodations, *[unless]* **or the most common charge for a private room if that is the only type of room available or if** a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.

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

*[(39)]***(58)** Incident. A definite and separate occurrence of a condition.

(59) Infertility. Any medical condition causing the inability or diminished ability to reproduce.

(60) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

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

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

*[(42)]***(63)** 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.

(64) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

*[(43)]***(65)** Lifetime. The period of time *[you or your]* **a member or the member's** eligible dependents participate in the plan.

*[(44)]***(66)** Lifetime maximum. The maximum amount payable by a medical plan during a covered member's life.

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

*[(46)]***(68)** 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.

(69) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

(70) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled comorbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.

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

(72) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.

*[(48)]***(73)** Non-formulary. A drug not contained on the *[health plan's or the]* pharmacy program's formulary list *[or preferred drug list]* **but may be covered under the terms and conditions of the plan**.

*[(49)]***(74)** 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)]***(75)** 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.

(76) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients convalescing from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations which are recognized under Medicare.

*[(51)]***(77)** 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)]***(78)** 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)]***(79)** Out-of-network. Providers that do not participate in the member's health **or pharmacy** plan.

(80) Out-of-pocket maximum. The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.

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

(82) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

(83) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

*[(55)]***(84)** 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)]***(85)** Participant. Any employee or dependent accepted for membership in the plan.

*[(57)]***(86)** 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, **and** manages the overall drug benefit of the plan*[,]* and processes claims payments.

*[(58)]***(87)** 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)]***(88)** 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)]***(89)** Plan. The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(61)]***(90)** 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)]***(91)** Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.

*[(63)]***(92)** Plan year. Same as *[benefit]* **calendar** 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)]***(93)** 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)]***(94)** 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)]***(95)** Pre-existing condition. A condition for which *[you have]* **a member has** incurred medical expenses or received treatment *[within the three (3) months]* prior to *[your]* **the** effective date of coverage.

*[(69)]***(96)** 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)]***(97)** Prevailing fee. The fee charged by the majority of dentists.

*[(71)]***(98)** 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]* **a medical plan**.

(99) Prior 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. Also know as pre-authorization or pre-notification.

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

(101) Private duty nursing. Private duty nursing services, nursing care on a full-time basis in the member's home, or home health aides.

(102) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

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

(104) Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and

(C) List of dependents covered.

*[(74)]***(105)** 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.

(106) Protected health information. Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(75)]***(107)** 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.

(108) Provider directory. A listing of network providers within a health plan.

(109) Prudent layperson. An individual possessing an average knowledge of health and medicine.

(110) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or an enrollee if the plan normally provides coverage for dependent children.

*[(76)]***(111)** 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)]***(112)** 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)]***(113)** Rehabilitation facility. A legally operating institution**,** or distinct part of an institution**,** that has a transfer agreement with one **(1)** or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary 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.

(114) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020(5)(B) and is currently receiving a monthly retirement benefit from one (1) of the retirement systems listed in such rule.

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

*[(80)]***(115)** 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) Severe obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hyptertension, hypertension or other obesity related conditions which will be considered based on clinical review.]

(116) Skilled nursing care. Care which must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

*[(82)]***(117)** 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).

*[(83)]***(118)** 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.

(119) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

*[(84)]***(120)** Specialty *[drugs]* **medications**. High cost drugs that are primarily self-injectible but sometimes oral medications.

*[(85)]***(121)** State. Missouri.

(122) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before stepping up to more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

*[(86)]***(123)** Subrogation. The substitution of one **(1)** "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.

*[(87)]***(124)** Subscriber. The employee or member who elects coverage under the plan.

(125) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.

(126) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

(127) Surgery center (ambulatory). A hospital based, sponsored, or independently-owned facility that performs surgery.

*[(88)]***(128)** Survivor. A member who meets the requirements of **subsection** 22 CSR 10-2.020(5)(A).

*[(89)]***(129)** 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-five (25) 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; **and**

(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)]***(87)** 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-five (25) (see **paragraph** 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); 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.

(130) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

(131) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(90)]***(132)** 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.

(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.

*[(91)]***(133)** 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.

*[(92)]***(134)** Vested subscriber. A member who meets the requirements of **subsection** 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 amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 AMENDMENT

22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5)–(8).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Subscriber Agreement and General Membership Provisions of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) The participant's initial application, any subsequently accepted modifications to such application, **the handbook,** and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any *[associated administrative guidelines]* **other written materials** interpret**ing** the subscriber agreement for the benefit of members and administrators *[but]* are not a part of the subscriber agreement.

(A) By applying for coverage under the MCHCP**,** a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks;

2. Individual and family deductibles, if appropriate, will be applied; and

3. Any individual eligible as an employee shall not be covered as a dependent unless the employee is on an approved leave of absence.

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

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date *[of]* **the** application **is received**, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if *[a life event*

occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;] **one (1) of the following occurs:**

A. Occurrence of a life event which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. Application must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case application for coverage through the plan must be made within sixty (60) days of loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation **except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a child is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the application**. 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**, except when adding a newborn**. 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).]* **following:**

(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*[.]***; and**

(II) Coverage is provided for a newborn of a member from the moment of birth. However, coverage will not continue past the first thirty-one (31) days unless required documentation is received;

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 spouse 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)]* **Birth certificate for newborn listing covered dependent as parent with baby's name and birth date**
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*[.]***;**

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;

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; **and**

[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)7.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and]

*[8.]***7.** Survivors, retirees, vested subscribers**,** and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage**, except when a dependent's employer-sponsored coverage ends due to one (1) of the following:**

A. Termination of employment;

B. Retirement; and

C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) Effective Date *[Proviso]* **Provision**. The effective date of coverage is the first of the month coinciding with or following *[your]* **the** 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.);

[(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan);

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.]

(D) Application for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's—

1. Employer-sponsored medical, dental, or vision plan terminates or coverage by the employer is no longer offered;

2. The employer contributions toward the premiums cease;

3. COBRA coverage ceases; or

4. A dependent no longer qualifies due to age;

(E) Application may be made for dependent coverage within sixty (60) days of the event—

1. A Qualified Medical Child Support Order is received; or

2. A dependent no longer qualifies for Medicaid; or

(F) Application may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.

(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:

(A) Written **or phone** request by the employee;

(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-five (25) 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-fifth 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).

(5) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if*[—]*

*[1. T]***t**he active employee was vested and eligible for a future retirement benefit*[; or]* **and**

[2. Your] eligible dependents meet one (1) of the following conditions:

*[A.]***1.** They have had coverage through MCHCP since the effective date of the last open enrollment period;

*[B.]***2.** They have had other health insurance for the six (6) months immediately prior to *[your]* **the employee's** death—proof of insurance is required; or

*[C.]***3.** They have had coverage through MCHCP since they were first eligible.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity**,** or the *[Highway Retirement System]* **Missouri Department of Transportation and Highway Patrol Employees' Retirement System** when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only*[,]* or employee and dependents) upon returning to employment directly from the leave*[, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members]*. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (3)(C). Coverage may be reinstated upon return from military leave *[without proof of insurability or preexisting conditions]*. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her

coverage in the plan at the same level of participation *[(employee only or employee and dependents)]* **(subscriber only or subscriber and dependents)** by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level *[(employee only, or employee and dependents)]* **(subscriber only or subscriber and dependents)** upon returning to employment*[, without proving insurability]*.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. *[No preexisting condition limitation will apply.]* If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. *[If the employee participates in a preferred provider organization (PPO) plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.]*

(6) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct **or receiving a reduction in the number of hours of employment** may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision**,** it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(7) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if *[you lose your]* **a member loses** group health insurance coverage because of a divorce, legal separation**,** or the death of *[your]* **a** spouse**,** *[you]* **the member** may continue coverage until age sixty-five (65) if: a) *[You]* **The member** continue**s** and maintain**s** coverage under the thirty-six (36)-month provision of COBRA; and b) *[You are]* **The member is** at least fifty-five (55) years old when *[your]* COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

(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;

(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

(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, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate *[review agency]* **claims administrator**. For emergency hospital admissions, the *[review agency]* **claims administrator** must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The *[review agency]* **claims administrator** will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members *[that]* **who** require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases**,** this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. *[(Note: The utilization review program will be operated in accordance with the administrative guidelines.)]*

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 amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 AMENDMENT

22 CSR 10-2.050 *[PPO and Co-Pay]* ***Copay Plan*** **Benefit Provisions and Covered Charges**. The Missouri Consolidated Health Care Plan is amending sections (1)–(4).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Copay Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) **Non-network** *[D]***d**eductible amount—per individual for the *[Preferred Provider Organization (PPO)]* **Copay** *[p]***P**lan each calendar year, *[five hundred dollars ($500)]* **six hundred dollars ($600)**, family limit each calendar year, one thousand **two hundred** dollars *[($1,000)]* **($1,200)**.

(2) 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) Coinsurance is seventy percent (70%) after deductible is met when utilizing non-network providers.

*[(A)]***(B)** 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)]***(C)** Claims may also be paid at eighty percent (80%) if *[you]* **the subscriber** requires covered services that are not available through a network provider *[in your area]* **within fifty (50) miles of his/her home**. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

*[(C)]***(D)** Non-network claims—**are paid at** seventy percent (70%) *[of the first four thousand dollars ($4,000)]* **until two thousand four hundred dollars ($2,400) has been met** for an individual, *[or of the first eight thousand dollars ($8,000)]* **four thousand eight hundred dollars ($4,800) has been met** for a family, of covered charges in the calendar year which are subject to coinsurance. **Claims are paid at** *[O]***o**ne 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.]*

(3) *[Co-payments]* **Copayments**—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 (3)(G).]

(A) Office visit—**primary care:** twenty-five dollars ($25)**; specialist: thirty-five dollars ($35)**.

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission**; one thousand two hundred dollars ($1,200) annual maximum inpatient copayment**.

(D) Maternity—**primary care:** twenty-five dollars ($25) for initial visit**; specialist: thirty-five dollars ($35)**.

(F) Outpatient surgery—*[seventy-five dollars ($75)]* **one hundred dollars ($100)**.

[(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.]

(G) Emergency room—one hundred dollars ($100) network and non-network.

(H) Urgent care—thirty-five dollars ($35) network and non-network.

(4) Out-of-pocket **non-network** 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 (3)(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)]***(A)** Non-network out-of-pocket maximum for individual—*[four thousand dollars ($4,000);]* **two thousand four hundred dollars ($2,400); and**

*[(D)]***(B)** Non-network out-of-pocket maximum for family—*[eight thousand dollars ($8,000);]* **four thousand eight hundred dollars ($4,800).**

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: copayments; 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 prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars ($300); family limit each calendar year, six hundred dollars ($600). Non-network: per individual each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(2) Coinsurance—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) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) 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.

(A) Network out-of-pocket maximum for individual—one thousand two hundred dollars ($1,200).

(B) Network out-of-pocket maximum for family—two thousand four hundred dollars ($2,400).

(C) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

(D) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: 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 prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) 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. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1)–(3) and (5).

PURPOSE: This amendment includes changes to the High Deductible Health Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—*[In]* Network: per individual *[for the High Deductible Health Plan (HDHP)]* each calendar year, one thousand two hundred dollars ($1,200)*[,]***;** family limit each calendar year, two thousand four hundred dollars ($2,400). Non-network: per individual *[for the High Deductible Health Plan (HDHP)]* each calendar year, two thousand four hundred dollars ($2,400)*[,]***;** family limit each calendar year, four thousand eight hundred dollars ($4,800).

(2) Coinsurance—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. *[Coinsurance is twenty percent (20%) after deductible is met when utilizing network providers. Coinsurance is forty percent (40%) after deductible is met when utilizing non-network providers. 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.]*

(A) Network claims—are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at eighty percent (80%) if the subscriber requires covered services that are not available through network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) 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.

(A) Network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400)*[;]***.**

(B) Network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800)*[;]***.**

(C) Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars ($4,800)*[;]***.**

(D) Non-network out-of-pocket maximum for family—nine thousand six hundred dollars ($9,600)*[;]***.**

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: 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 prior authorization; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) *[Prescription costs are applied to the medical plan deductible.]* **Pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medicare Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Eligibility—Subscribers and dependents covered in this plan must be enrolled in Medicare, and the subscribers must receive a monthly retirement benefit from either the Missouri State Employees' Retirement System (MOSERS) or from the Public School Retirement System (PSRS), based on years of service. A subscriber may enroll in this plan when first eligible for Medicare.

(2) Available services—The Medicare Supplement Plan covers coinsurance amounts on Medicare Parts A and B eligible benefits after the Medicare deductibles are met.

(A) Inpatient hospital care—covers Medicare Part A coinsurance plus coverage for three hundred sixty-five (365) additional days after Medicare coverage ends;

(B) Medical costs—covers Medicare Part B coinsurance;

(C) Blood—covers the first three (3) pints of blood each year; and

(D) Prescription drug coverage.

(3) Limitations and exclusions—

(A) Charges above Medicare allowed amounts are the member's responsibility; and

(B) Limitations and exclusions follow Medicare guidelines.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Benefit Provisions **Applicable to the HMO, Copay, PPO 300, and HDHP Plans**.

(A) Subject to the plan provisions and limitations and the written application of the employee, the benefits are payable for covered charges incurred by a participant while covered under the *[co-pay or preferred provider organization (PPO)]* plan**s**, provided the deductible requirement, if any, is met.

(D) The total amount of benefits payable for all covered charges incurred *[out-of]***non**-network during an individual's lifetime shall not exceed the lifetime maximum.

[(E) If both husband and wife are participating separately as employees under this plan, the family deductible and benefit features shall nevertheless apply to the benefit of the family unit.]

(2) Covered Charges **Applicable to the HMO, Copay, PPO 300, and HDHP Plans**.

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 amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 AMENDMENT

22 CSR 10-2.060 PPO *300 Plan*, HDHP, *[and Co-Pay]* *Copay, and HMO* Plan Limitations. The Missouri Consolidated Health Care Plan is amending sections (2) and (5); adding new sections (8), (17), (40), (44), and (48)–(51); renumbering and amending sections (8)–(37), (39)–(41), and (43)–(52); and removing sections (38) and (42).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the PPO 300 Plan, HDHP, Copay Plan, and HMO Limitations for members of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010*

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

(5) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, biofeedback, and other forms of alternative therapy **with the exception of aquatic therapy performed by a physical therapist**.

(8) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

*[(8)]***(9)** Care received without charge.

*[(9)]***(10)** Comfort and convenience items.

*[(10)]***(11)** 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)]***(12)** 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)]***(13)** 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)]***(14)** 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)]***(15)** Educational or psychological testing—not covered unless part of a treatment program for covered services.

*[(15)]***(16)** Examinations requested by a third party.

(17) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

*[(16)]***(18)** Exercise equipment.

*[(17)]***(19)** 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)]***(20)** 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)]***(21)** Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK**,** and other refractive eye surgery.

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

*[(21)]***(23)** 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)]***(24)** Health and athletic club membership—including costs of enrollment.

*[(23)]***(25)** Immunizations requested by third party or for travel.

*[(24)]***(26)** Infertility—*[not covered.]* **Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization).** Those health services and associated expenses for the treatment of infertility **are not covered,** 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 non-medically necessary amniocentesis.

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

*[(26)]***(28)** 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 **(1)** of its agencies; or

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

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

*[(28)]***(30)** Military service connected injury or illness.

*[(29)]***(31)** Non-network providers—subject to deductible and non-network coinsurance.

*[(30)]***(32)** Not medically necessary services—with the exception of preventive services.

*[(31)]***(33)** Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe **morbid** obesity as defined in 22 CSR 10-2.010 *[and such severe obesity has persisted for at least five (5) years]* **and satisfies all requirements described in the plan**. Bariatric surgery will only be covered when prior authorization is received from the medical plan. *[Please see the current State Member Handbook for further limitations regarding bariatric surgery.]*

(A) Bariatric surgery additional qualifying criteria—

1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled comorbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan based on clinical review;

2. Member must be eighteen (18) years of age or older;

3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;

4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;

5. Evidence the member and the attending physician have a life-long plan for compliance with lifestyle modification requirements;

6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and

7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.

(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.

(C) Revisions and corrections of bariatric procedures are covered only when the revision or correction is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).

*[(32)]***(34)** Orthognathic surgery.

*[(33)]***(35)** Orthoptics.

*[(34)]***(36)** Other charges—no coverage for charges that would not be incurred if *[you were]* **the subscriber was** not covered. Charges for which *[you]* **the subscriber** or *[your]* **his/her** dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in *[your]* **the subscriber's** name but which are actually due to the injury or illness of a different person not covered by the plan. **Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.**

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

*[(36)]***(38)** 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)]***(39)** Physical fitness.

(40) Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

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

*[(39)]***(41)** Private duty nursing.

*[(40)]***(42)** 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)]***(43)** Services not specifically included as benefits.

(44) Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

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

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

*[(44)]***(46)** Surrogacy—pregnancy coverage is limited to plan member.

*[(45)]***(47)** Temporo-Mandibular Joint Syndrome (TMJ).

(48) Third-party examinations.

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

(50) Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.

(51) Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar ($10,000) maximum per transplant when accessing network services.

*[(46)]***(52)** 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)]***(53)** Travel expenses—not covered unless authorized by claims administrator.

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

*[(49)]***(55)** Usual, Customary**,** and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

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

*[(51)]***(57)** 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)]***(58)** 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]* **charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other legislation of similar program**.

AUTHORITY: section 103.059, RSMo 2000 ***and section 103.080.3, RSMo Supp. 2008****. 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, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 AMENDMENT

22 CSR 10-2.064 HMO *[and POS]* **Summary of Medical Benefits**. The Missouri Consolidated Health Care Plan is amending sections (1) and (2).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to HMO Summary of Medical Benefits for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Co*[-]*payments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—**primary care:** twenty-five dollars ($25)**; specialist: thirty-five dollars ($35)**.

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission**; one thousand two hundred dollars ($1,200) annual maximum inpatient copayment**.

(D) Maternity—**primary care:** twenty-five dollars ($25) for initial visit**; specialist: thirty-five dollars ($35)**.

(F) Outpatient surgery—*[seventy-five dollars ($75)]* **one hundred dollars ($100)**.

(G) Emergency room—one hundred dollars ($100).

(H) Urgent care—thirty-five dollars ($35).

(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. **The total annual premium is any amount paid by, or on behalf of, the member.**

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 amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 10-2.067 HMO and POS Limitations. This rule established the limitations and exclusions of the Missouri Consolidated Health Care Plan HMO and/or POS Plan.

PURPOSE: This rule is being rescinded because the limitations have been incorporated into another rule.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2010, 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 rescission be effective immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2010, 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. A proposed rescission, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rescission was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

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 rescission filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 10-2.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the HMO, Copay, PPO 300, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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, beginning with the first day of coverage for the new plan year. It is imperative that this rule be effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

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

(A) Medications.

1. Network:

A. Generic: Eight dollar ($8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. Formulary brand: Thirty-five dollar ($35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

C. Non-formulary: Fifty-five dollar ($55) copayment for up to a thirty (30)-day supply for non-formulary drug;

D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;

E. Mail order program—

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for two and one-half (2 ½) regular copayments.

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments:

(a) Generic: six dollars and sixty-seven cents ($6.67);

(b) Formulary brand: twenty-nine dollars and seventeen cents ($29.17); and

(c) Non-formulary: forty-five dollars and eighty-three cents ($45.83).

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 and 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 copayment. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

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

(3) Retail and mail order coverage includes the following (except for specialty drugs):

(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) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five-hundred dollar ($500) annual benefit.

(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 copayment 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 copayment 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 copayment 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; and

(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 copayment applies; or

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

(C) A drug is determined to have a safety issue.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. Emergency rescission filed Dec. 21, 2006, effective Jan. 1, 2007, expired June 29, 2007. Rescinded: Filed Dec. 21, 2006, effective June 30, 2007. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending section (1) and breaking it into new sections and adding several new sections.

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Definitions of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

[(1) When used in this chapter's rules or the public entity member handbook, these words and phrases have the meaning—]

*[(A)]***(1)** Accident*[—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;]***. 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.**

[(B) 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;]

(2) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, plan changes, etc.

*[(C)]***(3)**Administrative guidelines*[—The]***. Instructive** 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*[;]***.**

[(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12)-month period beginning January 1 and ending December 31;]

(4) 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.

(5) 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.

(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.

(7) Benefit period. The three hundred sixty-five (365) days immediately following the first date of like services.

*[(F)]***(8)** Benefits*[—]***.** Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator*[;]***.**

[(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;]

(9) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.

(10) Board. The board of trustees of the Missouri Consolidated Health Care Plan.

(11) Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.

(12) Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.

*[(H)]***(13)** Claims administrator*[—]***.** An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs *[and preferred provider organization (PPO);]***, including but not limited to the preferred provider organization (PPO) (also known as the copay plan) and health maintenance organization (HMO) type plans.**

(14) Coinsurance. The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.

(15) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses such as deductible or coinsurance.

(16) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

(17) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics." CCCs are usually staffed by nurse practitioners or physician assistants. Some CCCs, however, are staffed by physicians.

(18) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.

(19) Copay plan. A set of benefits similar to a health maintenance organization option.

(20) Copayment. A set dollar amount that the covered individual must pay for specific services.

*[(I)]***(21)** Cosmetic surgery*[—]***.** A procedure performed primarily **for psychological purposes or** to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury*[;]***.**

*[(J)]***(22)** Covered benefits **and charges.** *[—]* 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.**

*[(K)]***(23)** Custodial care**.** *[—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;]* **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 and require the continuing attention of trained medical or paramedical personnel.**

(24) Date of service. Date medical services are received or performed.

(25) 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.

*[(L)]***(26)** Dependent-only participation*[—]***.** Participation of certain survivors of *[employees]* **subscribers**. Dependent participation may be further defined to include the deceased *[employee's]* **subscriber's**:

*[1)]***(A)** *[s/]***S**pouse only;

*[2)]***(B)** *[c/]***C**hild(ren) only; or

*[3)]***(C)** *[s/]***S**pouse and child(ren)*[;]***.**

*[(M)]***(27)** 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*[;]*.

(28) Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges 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.

(29) Disposable supplies. Medical supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.

(30) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:
(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental surgery; or
(H) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practice of spiritual healing are well established and recognized.

(31) 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.

*[(N)]***(32)** Eligibility date*[—]*. Refer to 22 CSR 10-3.020 for effective date provisions. *[1.]* 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 eligibility as determined by the employer.

*[(O)]***(33)** Emancipated child(ren)*[—]*. A child(ren) who is—
*[1.]***(A)** Employed on a full-time basis;
*[2.]***(B)** Eligible for group health benefits in his/her own behalf;
*[3.]***(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
*[4.]***(D)** Married*[;]*.

(34) Emergency. Any medical condition leading a prudent layperson to seek immediate medical attention. This normally means the sudden onset of a health condition that manifests itself by acute symptoms and severity (including severe pain). Examples of medical emergencies include, but are not limited to:
(A) Conditions placing a person's health in significant jeopardy;
(B) Serious impairment to a bodily function;
(C) Serious dysfunction of any bodily organ or part;
(D) Inadequately controlled pain; or
(E) Situations when the health of a pregnant woman or her unborn child are threatened.

(35) Emergency room. The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.

*[(P)]***(36)** Employee and dependent participation*[—]*. Participation of an employee and the employee's eligible dependents. *[Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren).]* Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-3.030(1)(A)*[9.;]***7. 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).

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

*[(R)]***(37)** Employees*[—]*. Employees of the participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity*[;]*.

*[(S)]***(38)** Employer*[—]*. The public entity that employs the eligible employee as defined above*[;]*.

*[(T)]***(39)** Executive director*[—]*. The *[administrator]* **chief executive officer** of the Missouri Consolidated Health Care Plan (MCHCP) who *[reports directly to the plan administrator;]* **shall have charge of the offices, records, and employees of the plan, subject to the direction of the board.**

(40) 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 clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its 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.

(41) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date the dependent meets the eligibility requirements for coverage under the plan.

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

(43) Generic drug. A chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

(44) 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.

(45) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

(46) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference will be made available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2010 State Member Handbook (January 1, 2010). It does not include any later amendments or additions.

[(U) Health maintenance organization (HMO)—An organization that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;]

(47) Health savings account (HSA). A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.

(48) High Deductible Health Plan (HDHP). A health plan with higher deductibles than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

*[(V)]***(49)** Home health agency*[—]***.** An agency certified by **Medicare and** 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*[;]***.**

*[(W)]***(50)** Hospice*[—A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill;]***. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.**

(51) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

*[(X)]***(52)** Hospital.

*[1.]***(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.

*[2.]***(B)** An institution not meeting all the requirements of *[(1)(X)1. of this rule]* **(52)(A) above**, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

*[3.]***(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).

*[4.]***(D)** A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

*[5.]***(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*[;]***.**

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

(54) Hospital room charges. The hospital's most common charge for semi-private accommodations, or the most common charge for a private room if that is the only type of room available or if a private room has been recommended by a physician and approved by the claims administrator or the plan administrator.

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

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

(57) Infertility. Any medical condition causing the inability or diminished ability to reproduce.

(58) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.

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

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

(61) 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.

(62) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

*[(Y)]***(63)** Lifetime*[—]***.** The period of time *[you or your]* **a member or the member's** eligible dependents participate in the plan*[;]***.**

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

*[(Z)]***(65)** Medical benefits coverage*[—]***.** Services that are received from providers recognized by the plan and are covered benefits under the plan*[;]***.**

*[(AA)]***(66)** Medically necessary*[—Services and/or supplies usually rendered or prescribed for the specific illness or injury;]***. 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;

(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 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.

(67) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

(68) Morbid obesity. Body Mass Index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled comorbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions approved by the plan administrator based on clinical review.

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

(70) Non-embedded deductible. The family deductible that must be met before claim payments begin, applicable when two (2) or more family members are covered in the HDHP.

(71) Non-formulary. A drug not contained on the pharmacy program's formulary list but may be covered under the terms and conditions of the plan.

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

*[(BB)]***(73)** 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*[;]***.**

(74) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients convalescing from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations which are recognized under Medicare.

*[(CC)]***(75)** 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*[;]***.**

*[(DD)]***(76)** 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*[;]***.**

*[(EE)]***(77)** Out-of-network*[—]***.** Providers that do not participate in the member's health **or pharmacy** plan*[;]***.**

(78) Out-of-pocket maximum. The maximum amount the member must pay before the plan begins paying one hundred percent (100%) of covered charges for the remainder of the calendar year.

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

(80) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

(81) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

(82) 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.

*[(FF)]***(83)** Participant*[—]***.** Any employee or dependent accepted for membership in the plan*[;]***.**

(84) 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, and manages the overall drug benefit of the plan and processes claims payments.

*[(GG)]***(85)** 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*[;]***.**

*[(HH)]***(86)** Physician/Doctor*[—]***.** A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo*[;]***.**

*[(II)]***(87)** Plan*[—]***.** The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law*[;]***.**

*[(JJ)]***(88)** 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.

*[(KK)]***(89)** Plan document*[—]***.** The statement of the terms and conditions of the plan as *[adopted by the plan administrator in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook" with respect to dental and vision coverage and incorporated by reference in this rule, as published in August 2004 by the Missouri Consolidated Health Care Plan, PO Box 104355, Jefferson City, MO 65110. This rule does not incorporate any subsequent amendments or additions. Note: The plan documents for medical plans are provided by the fully-insured contractors of such plans, and such plan documents may be obtained by contacting those contractors directly. The names, addresses, and phone numbers of the fully-insured contractors may be found in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook";]* **promulgated by the plan administrator in this chapter.**

*[(LL)]***(90)** Plan year*[—]***.** Same as *[benefit]* **calendar** year*[;]***.**

[(MM) 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;

(NN) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;]

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

(92) Pre-certification. 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).

(93) Pre-existing condition. A condition for which a member has incurred medical expenses or received treatment prior to the effective date of coverage.

*[(OO)]***(94)** 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*[;]***.**

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

(96) Primary care physician (PCP). A physician (usually an internist, family/general practitioner, or pediatrician) who has contracted with and been approved by a medical plan.

(97) Prior 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. Also known as pre-authorization or pre-notification.

*[(PP)]***(98)** Prior plan*[—]***.** The terms and conditions of a plan in effect for the period preceding coverage in the *[MCHCP;]* **plan.**

(99) Private duty nursing. Private duty nursing services, nursing care on a full-time basis in the member's home, or home health aides.

(100) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.

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

(102) Proof of prior coverage. If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:

(A) Date coverage was or will be terminated;

(B) Reason for coverage termination; and

(C) List of dependents covered.

(103) 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.

(104) Protected health information. Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.

*[(QQ)]***(105)** 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*[;]***.**

(106) Provider directory. A listing of network providers within a health plan.

(107) Prudent layperson. An individual possessing an average knowledge of health and medicine.

*[(RR)]***(108)** Public entity*[—]***.** A state-sponsored institution of higher learning, political subdivision, or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board*[;]***.**

(109) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or an enrollee if the plan normally provides coverage for dependent children.

(110) 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.

(111) 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.

(112) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary 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.

(113) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(6)(B) and is currently receiving a monthly retirement benefit from one (1) of the retirement systems listed in such rule.

[(SS) Review agency—A company responsible for administration of clinical management programs;]

*[(TT)]***(114)** 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*[;]***.**

(115) Skilled nursing care. Care which must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

*[(UU)]***(116)** Skilled nursing facility (SNF)*[—]***.** An institution which meets fully each of the following requirements:

*[1.]***(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;

*[2.]***(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

*[3.]***(C)** A skilled nursing facility shall be deemed to include institutions meeting the criteria in *[subsection (1)(UU) 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)*[;]***.**

(117) 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.

(118) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

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

*[(VV)]***(120)** State*[—]***.** Missouri*[;]***.**

(121) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before stepping up to more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

(122) Subrogation. The substitution of one (1) "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.

*[(WW)]***(123)** Subscriber*[—]***.** The employee or member who elects coverage under the plan*[;]***.**

(124) Subscriber only participation. Participation of a subscriber without participation of the subscriber's dependents, whether or not the subscriber has dependents.

(125) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

(126) Surgery center (ambulatory). A hospital based, sponsored, or independently-owned facility that performs surgery.

*[(XX)]***(127)** Survivor*[—]***.** A member who meets the requirements of **subsection** 22 CSR 10-3.020(6)(A)*[;]***.**

*[(YY)]***(128)** 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-five (25) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

*[1.]***(A)** Stepchild(ren);

*[2.]***(B)** Foster child(ren) for whom the employee is responsible for health care;

*[3.]***(C)** Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care; **and**

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

(E) Except for a disabled child(ren) as described in *[sub]*section *[(1)(GG)]***(85)** 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-five (25) (see **paragraph** 22 CSR 10-3.020(4)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-five (25)); and

*[5.]***(F)** 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*[;]***.**

(129) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate

for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

(130) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.

*[(ZZ)]***(131)** Usual, *[c]***C**ustomary, and *[r]***R**easonable *[c]***C**harge*[—]***.**

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

*[2.]***(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*[;]***.**

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

*[4.]***(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*[; and]***.**

(132) 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.

*[(AAA)]***(133)** Vested subscriber*[—]***.** A member who meets the requirements of **subsection** 22 CSR 10-3.020(6)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (1), (3), (4), and (6)–(9).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the subscriber agreement and general membership provisions of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) The participant's initial application, any subsequently accepted modifications to such application, **the handbook,** and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any *[associated administrative guidelines]* **other written materials** interpret**ing** the subscriber agreement for the benefit of members and administrators *[but]* are not part of the subscriber agreement.

(A) By applying for coverage under the MCHCP**,** a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks; and

2. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the prior plan may be credited for those joining one **(1)** of the preferred provider organization (PPO) options. Appropriate proof of said deductibles will be required.

(3) The effective date of participation shall be determined, subject to the effective date provision in subsection (3)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date *[of]* **the** application **is received**, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if *[a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;]* **one (1) of the following occurs:**

A. Occurrence of a life event which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

B. Loss of a spouse's employer-sponsored group coverage when the employee originally waived coverage through the plan. Application must be made within sixty (60) days of the time—

(I) The employee no longer qualifies for coverage under spouse's plan;

(II) The spouse's employment terminates or he/she is no longer eligible for coverage under employer's plan;

(III) The spouse's employer-sponsored medical, dental, and/or vision plan terminates;

(IV) All employer contributions toward the spouse's plan cease; or

(V) The employee's Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

C. Loss of eligibility for Medicaid, in which case application for coverage through the plan must be made within sixty (60) days of the loss;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation **except when coverage is added as a life event with birth of a child or adoption of a child at birth. The effective date for a child is the date of birth. The subscriber and/or dependent's effective date is the first day of the calendar month coinciding with or following the date of the application**. Application for participants must be made in accordance with the following provisions*[.]***:**

1. 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.]***2.** 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.]***3.**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; **and**

[3. 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 (3)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and]

4. Survivors, retirees, vested subscribers**,** and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage*[;]***, except when a dependent's employer-sponsored coverage ends due to one (1) of the following:**

A. Termination of employment;

B. Retirement; and

C. Termination of group coverage by the employer.

Coverage must have been in place for twelve (12) months immediately prior to the loss, and coverage must be requested within sixty (60) days from the termination date of the previous coverage;

(C) Effective Date *[Proviso]* **Provision**.

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. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity;

[(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan); and

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.]

(D) Application for dependent coverage may be made within sixty (60) days when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's:

1. Employer-sponsored medical plan terminates or coverage by the employer is no longer offered;

2. The employer contributions toward the premiums cease; or

3. A dependent no longer qualifies due to age;

(E) Application may be made for dependent coverage within sixty (60) days of the event—

1. A Qualified Medical Child Support Order is received;

2. A dependent no longer qualifies for Medicaid; or

(F) Application may be made for dependent coverage within thirty-one (31) days of an emancipated dependent regaining dependent status.

(4) 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 (5) and (6).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally *[retarded]* and/or physically handicapped children will continue to be eligible beyond age twenty-five (25) 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-fifth 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 (6).

(6) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if *[—]*

*[1. T]***t**he active employee was vested and eligible for a future retirement benefit*[; or]* **and**

[2. Your] eligible dependents meet one (1) of the following conditions:

*[A.]***1.** They have had coverage through MCHCP since the effective date of the last open enrollment period;

*[B.]***2.** They have had other health insurance for the six (6) months immediately prior to *[your]* **the employee's** death—proof of insurance is required; or

*[C.]***3.** They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility Criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the retirement system of the participating public entity may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers**,** and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in *[(7)(B)4.]* **paragraph (6)(B)4.**; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only*[,]* or employee and dependents) upon returning to employment directly from the leave*[, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members]*. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection *[(5)(C)]***(4)(C)**. Coverage may be reinstated upon return from military leave *[without proof of insurability or preexisting conditions]*. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation *[(employee only or employee and dependents)]* **(subscriber only or subscriber and dependents)** by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level *[(employee only, or employee and dependents)]* **(subscriber only or subscriber and dependents)** upon returning to employment*[, without proving insurability]*.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. *[No preexisting condition limitation will apply.]* If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. *[If the employee participates in a PPO plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.]*

(7) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct **or receiving a reduction in the number of hours of employment** may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent

(150%) if disabled. Once coverage is terminated under the COBRA provision**,** it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(8) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if *[you lose your]* **a member loses** group health insurance coverage because of a divorce, legal separation**,** or the death of *[your]* **a** spouse**,** *[you]* **the member** may continue coverage until age sixty-five (65) if: a) *[You]* **The member** continue**s** and maintain**s** coverage under the thirty-six (36)-month provision of COBRA; and b) *[You are]* **The member is** at least fifty-five (55) years old when *[your]* COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

[(9) 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)]***(9)** 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. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Emergency amendment filed Dec. 20, 2007, effective Jan. 1, 2008, expired June 28, 2008. Amended: Filed Dec. 20, 2007, effective June 30, 2008. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment includes changes to the policy of the board of trustees in regard to the Public Entity Membership Agreement and Participation Period of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2010, 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. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency amendment was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) The application packet, participation agreement, and confirmation notice shall comprise the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under the MCHCP**,** a public entity agrees that—

1. The MCHCP will be the only health care offering made to its eligible members;

[2. If the public entity participated in the MCHCP during calendar year 2004 and continues to participate each year subsequent to calendar year 2004, that public entity shall only be required to contribute twenty-five dollars ($25) per month towards the employee only premium for each active employee's premium for the plan(s) offered through MCHCP during calendar years 2005 and 2006;]

*[3.]***2.** *[If the public entity did not participate in the MCHCP during calendar year 2004, that]* **The** public entity shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

[4. Beginning January 1, 2007, all public entities shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;]

*[5.]***3.** For public entities with less than twenty-five (25) employees, the public entity shall only offer one (1) plan choice to its employees. For public entities with twenty-five (25) or more employees, the public entity may offer *[more than one (1)]* **two (2)** plans *[choice]* provided by MCHCP*[.]***;**

*[6.]***4.** For public entities with more than a total of three (3) employees, at least seventy-five percent (75%) of all eligible employees must join the MCHCP*[. For public entities with three (3) or fewer employees, a minimum of one (1) employee must join the MCHCP. For public entities with three (3) or fewer employees who fail to have one (1) employee participating in the MCHCP, MCHCP will allow the public entity up to the remainder of the period remaining in the latest participation agreement in which to attempt to meet the participation requirements before terminating for failure to meet the participation requirements]*;

*[7.]***5.** Individual and family deductibles, if applicable, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining *[one of the PPO options]* **MCHCP**. Appropriate proof of said deductibles will be required;

*[8.]***6.** An eligible employee is one that is not covered by another group sponsored plan;

*[9.]***7.** Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees in consideration of section (6); and

*[10.]***8.** A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective.

(B) *[Effective January 1, 2001, i]***I**n order to provide retiree coverage, any participating member agency joining MCHCP must have one **(1)** of the criteria listed below. If neither of these scenarios is applicable and no retirement plan exists, no "retirees" would exist, so there would be no retiree eligibility.

1. An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. The employer must offer coverage to retirees who have met this minimum vesting period requirement.

2. An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, in order to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to Missouri State Employees' Retirement System (MOSERS). If this criterion was not met, the employer may not offer coverage to that person as a retiree.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate claims administrator. For emergency hospital admissions, the claims administrator must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The claims administrator will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members who require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases**,** this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.050 Copay Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Copay Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Non-network deductible amount—per individual for the Copay Plan each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(2) 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) Coinsurance is seventy percent (70%) after deductible is met when utilizing non-network providers.

(B) 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.

(C) Claims may also be paid at eighty percent (80%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(D) Non-network claims—are paid at seventy percent (70%) until two thousand four hundred dollars ($2,400) has been met for an individual, four thousand eight hundred dollars ($4,800) has been met for a family, of covered charges in the calendar year which are subject to coinsurance. Claims are paid at one hundred percent (100%) of any excess covered charges in the calendar year.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—primary care: twenty-five dollars ($25); specialist: thirty-five dollars ($35).

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

(C) Inpatient hospitalizations—three hundred dollars ($300) per admission; one thousand two hundred dollars ($1,200) annual maximum inpatient copayment.

(D) Maternity—primary care: twenty-five dollars ($25) for initial visit; specialist: thirty-five dollars ($35).

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

(F) Outpatient surgery—one hundred dollars ($100).

(G) Emergency room—one hundred dollars ($100) network and non-network.

(H) Urgent care—thirty-five dollars ($35) network and non-network.

(4) Out-of-pocket non-network 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.

(A) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400); and

(B) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; 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 prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) 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. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.051 PPO 300 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 300 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars ($300); family limit each calendar year, six hundred dollars ($600). Non-network: per individual each calendar year, six hundred dollars ($600); family limit each calendar year, one thousand two hundred dollars ($1,200).

(2) Coinsurance—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) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within fifty (50) miles of his/her home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) 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.

(A) Network out-of-pocket maximum for individual—one thousand two hundred dollars ($1,200).

(B) Network out-of-pocket maximum for family—two thousand four hundred dollars ($2,400).

(C) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

(D) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: 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 prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) 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. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.052 PPO 500 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 500 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, five hundred dollars ($500); family limit each calendar year, one thousand five hundred dollars ($1,500). Non-network: per individual each calendar year, one thousand dollars ($1,000); family limit each calendar year, three thousand dollars ($3,000).

(2) Coinsurance—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) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; Non-network: seventy percent (70%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(4) 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.

(A) Network out-of-pocket maximum for individual—two thousand five hundred dollars ($2,500).

(B) Network out-of-pocket maximum for family—seven thousand five hundred dollars ($7,500).

(C) Non-network out-of-pocket maximum for individual—seven thousand dollars ($7,000).

(D) Non-network out-of-pocket maximum for family—twenty-one thousand dollars ($21,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; 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 prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) 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. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars ($1,000); family limit each calendar year, three thousand dollars ($3,000). Non-network: per individual each calendar year, two thousand dollars ($2,000); family limit each calendar year, six thousand dollars ($6,000).

(2) Coinsurance—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) Network claims—are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at ninety percent (90%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty dollars ($20), specialist—thirty dollars ($30); Non-network: seventy percent (70%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty dollars ($20) for initial visit, specialist—thirty dollars ($30) for initial visit; Non-network: seventy percent (70%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(4) 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.

(A) Network out-of-pocket maximum for individual—four thousand five hundred dollars ($4,500).

(B) Network out-of-pocket maximum for family—thirteen thousand five hundred dollars ($13,500).

(C) Non-network out-of-pocket maximum for individual—ten thousand dollars ($10,000).

(D) Non-network out-of-pocket maximum for family—thirty thousand dollars ($30,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; 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 prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) 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. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 2000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars ($2,000); family limit each calendar year, six thousand dollars ($6,000). Non-network: per individual each calendar year, four thousand dollars ($4,000); family limit each calendar year, twelve thousand dollars ($12,000).

(2) Coinsurance—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) Network claims—are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at eighty percent (80%) if required covered services are not available through a network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) Copayments—set charges for the following types of claims so long as network providers are utilized.

(A) Office visit—Network: primary care—twenty-five dollars ($25), specialist—thirty-five dollars ($35); Non-network: sixty percent (60%) coinsurance after deductible.

(B) Maternity—Network: primary care—twenty-five dollars ($25) for initial visit, specialist—thirty-five dollars ($35) for initial visit; Non-network: sixty percent (60%) coinsurance after deductible.

(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.

(D) Emergency room—Network: one hundred dollar ($100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar ($100) copayment (waived if admitted as inpatient).

(E) Urgent care—Network: fifty dollar ($50) copayment; Non-network: fifty dollar ($50) copayment.

(4) 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.

(A) Network out-of-pocket maximum for individual—six thousand dollars ($6,000).

(B) Network out-of-pocket maximum for family—eighteen thousand dollars ($18,000).

(C) Non-network out-of-pocket maximum for individual—twelve thousand dollars ($12,000).

(D) Non-network out-of-pocket maximum for family—thirty-six thousand dollars ($36,000).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; 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 prior authorization; coinsurance amounts related to infertility benefits; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) 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. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the High Deductible Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars ($1,200); family limit each calendar year, two thousand four hundred dollars ($2,400). Non-network: per individual each calendar year, two thousand four hundred dollars

($2,400); family limit each calendar year, four thousand eight hundred dollars ($4,800).

(2) Coinsurance—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) Network claims—are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims—are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(C) Emergency services and urgent care are paid as network benefits from network and non-network providers.

(D) Claims may also be paid at eighty percent (80%) if required covered services are not available through network provider within fifty (50) miles of the member's home. The participant must contact the claims administrator in order to have a local provider approved. Such approval is not permanent.

(3) 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.

(A) Network out-of-pocket maximum for individual—two thousand four hundred dollars ($2,400).

(B) Network out-of-pocket maximum for family—four thousand eight hundred dollars ($4,800).

(C) Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars ($4,800).

(D) Non-network out-of-pocket maximum for family—nine thousand six hundred dollars ($9,600).

(E) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: 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 prior authorization; and charges above the maximum allowable amount for transplants performed by a non-network provider.

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

(5) Pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.060 PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, PPO 2000 Plan, HDHP, and Copay Plan Limitations

PURPOSE: This rule establishes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, PPO 2000 Plan, HDHP, and/or Copay Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.*

(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 do not receive prior authorization as described in 22 CSR 10-3.045, 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 with the exception of aquatic therapy performed by a physical therapist.

(6) Autopsy.

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

(8) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.

(9) Care received without charge.

(10) Comfort and convenience items.

(11) 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.

(12) 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.

(13) 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.

(14) 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.

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

(16) Examinations requested by a third party.

(17) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.

(18) Exercise equipment.

(19) 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.

(20) 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.

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

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

(23) 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.

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

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

(26) Infertility—Infertility treatments are limited to in-vivo (intrauterine, intracervical, intravaginal fertilization). Those health services and associated expenses for the treatment of infertility are not covered, 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 non-medically necessary amniocentesis.

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

(28) 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.

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

(30) Military service connected injury or illness.

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

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

(33) Obesity—medical and surgical intervention is not covered, unless the member meets the definition of severe morbid obesity as defined in 22 CSR 10-3.010 and satisfies all requirements described in the plan. Bariatric surgery will only be covered when prior authorization is received from the medical plan.

(A) Bariatric surgery additional qualifying criteria—

1. Presence of severe morbid obesity that has persisted for at least five (5) years defined as body mass index (BMI) greater than or equal to forty (40) or BMI greater than or equal to thirty-five (35) with at least two (2) or more of the following uncontrolled co-morbidities: coronary heart disease, type 2 diabetes mellitus, clinically significant obstructive sleep apnea, pulmonary hypertension, hypertension, or other obesity related conditions will be considered based on clinical review;

2. Member must be eighteen (18) years of age or older;

3. Documented evidence of at least two (2) failed attempts at weight loss each with a minimum duration of at least six (6) months with the member achieving at least a ten percent (10%) weight loss and meeting the following additional criteria: one (1) attempt must be in a physician-supervised weight loss program and fully documented in the physician's record; the program must use a multidisciplinary approach including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification; nationally recognized program such as Jenny Craig or Weight Watchers (This does not include self-directed low-calorie diets such as the Atkins Diet or South Beach Diet.); and the most recent attempt must have been within the twelve (12)-month period prior to the requested surgery;

4. Documented evidence the member is on a nutrition and exercise program immediately prior to the surgery request;

5. Evidence the member and the attending physician have a lifelong plan for compliance with lifestyle modification requirements;

6. Documentation the member has completed a psychological evaluation and, if appropriate, behavior modification and should be free of major psychiatric diagnosis or a current behavior which would significantly reduce long-term effectiveness of the proposed treatment; and

7. Procedure must be performed at a Centers of Excellence (COE) facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services.

(B) Network services are limited to one (1) operative procedure for the treatment of obesity per lifetime. Non-network obesity services are not covered.

(C) Revisions and corrections of bariatric procedures only when the revision is used to treat life-threatening complications (e.g. wound infection, abscess, dehiscence, gastric leaking, and embolism). Coverage is limited to the following bariatric procedures: Roux-en-Y Gastric Bypass—open and laparoscopic (RYGBP),

Laparoscopic Adjustable Gastric Banding (LAGB), and Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS).

(34) Orthognathic surgery.

(35) Orthoptics.

(36) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment (unless the scheduled appointment was for a mental health service), or any late payment charge.

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

(38) 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.

(39) Physical fitness.

(40) Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.

(41) Private duty nursing.

(42) 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.

(43) Services not specifically included as benefits.

(44) Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.

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

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

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

(48) Third-party examinations.

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

(50) Transplants—double listing—payment only for one (1) evaluation up to time of actual transplant.

(51) Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar ($10,000) maximum per transplant when accessing network services.

(52) 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.

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

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

(55) Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.

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

(57) 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.

(58) Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other legislation of similar program.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.090 Pharmacy Benefit Summary

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for Copay Plan, PPO 300 Plan, PPO 500 Plan, PPO 1000 Plan, and PPO 2000 Plan of the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2010, 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 effective immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2010, 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. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. 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. This emergency rule was filed December 22, 2009, becomes effective January 1, 2010, and expires on June 29, 2010.

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

(A) Medications.

1. Network:

A. Generic: Eight dollar ($8) copayment for up to a thirty (30)-day supply for generic drug on the formulary;

B. Formulary brand: Thirty-five dollar ($35) copayment for up to a thirty (30)-day supply for brand drug on the formulary;

C. Non-formulary: Fifty-five dollar ($55) copayment for up to a thirty (30)-day supply for non-formulary drug;

D. Prescriptions filled with a formulary brand drug when there is a Food and Drug Administration (FDA)-approved generic will be subject to the generic copayment amount in addition to paying the difference between the cost of the generic and the formulary brand drug;

E. Mail order program—

(I) Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for two and one-half (2 ½) regular copayments.

(II) Specialty drugs covered only through network mail order for up to thirty (30) days. Copayments:

(a) Generic: six dollars and sixty-seven cents ($6.67);

(b) Formulary brand: twenty-nine dollars and seventeen cents ($29.17); and

(c) Non-formulary: forty-five dollars and eighty-three cents ($45.83).

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 and 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 copayment. All such claims must be filed within twelve (12) months of the incurred expense.

3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

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

(3) Retail and mail order coverage includes the following (except for specialty drugs):

(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) Tobacco cessation prescriptions—subject to formulary restrictions and limited to five hundred dollar ($500) annual benefit.

(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 copayment 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 copayment 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 copayment 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; and

(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 copayment applies; or

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

(C) A drug is determined to have a safety issue.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expires June 29, 2010. 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. 2009.

EXECUTIVE ORDER
09-28

WHEREAS, Missouri has produced some of the most outstanding poets and writers of our time, including Samuel Clemens, Ernest Hemingway, T.S. Eliot, Langston Hughes, Tennessee Williams, Maya Angelou, and Laura Ingalls Wilder; and

WHEREAS, our poets, and their poetry, help define our humanity, and have contributed immeasurably to the culture of our state, the nation, and the world; and

WHEREAS, an awareness and appreciation of poetry increases literacy, creativity, and advanced communication skills; and

WHEREAS, a great poem is capable of lifting our spirits, healing old wounds, creating bonds that last, and bridging any divide.

NOW, THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and the laws of the state of Missouri, do hereby establish the post of Missouri Poet Laureate.

The Poet Laureate shall be named in January, 2010, and biennially thereafter, and shall serve for two years, at the pleasure of the Governor. In addition to other criteria established, the Poet Laureate must be a published poet, a resident of Missouri, be active in the poetry community, and be willing and able to promote poetry in the state of Missouri throughout the two-year term. The Poet Laureate shall be responsible for promoting the arts in Missouri by making public appearances at public libraries and schools across the state. The Poet Laureate shall also compose an original poem in honor of Missouri that may be used for publication and distribution.

The Poet Laureate shall be selected by the Governor from open nominations solicited from across the state. The Missouri Poet Laureate Advisory Committee is hereby created and established, and shall be comprised of three members of the Missouri Center for the Book and two members appointed by the Governor. The Advisory Committee shall meet as necessary to assist in soliciting, publicizing, and encouraging nominations; to recommend appropriate additional criteria for the nomination process and for the post; to review and evaluate nominees; and to make recommendations to the Governor for appointment to the post of Missouri Poet Laureate. All members of the Advisory Committee shall have expertise in contemporary American poetry, and shall serve at the pleasure of the Governor.

Following the Governor's selection of a Poet Laureate in January of 2010, the Advisory Committee shall next meet in September, 2011 to begin work on the nomination process for the succeeding Poet Laureate, and shall convene for such purpose thereafter every other year.

Executive Order 08-01 is hereby superseded and replaced by this Executive Order.

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 24th day of December, 2009.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Robin Carnahan
Secretary of State

EXECUTIVE ORDER
09-29

WHEREAS, the state of Missouri experiences emergencies due to tornadoes, rain, snow, flood and ice as well as other unforeseen events requiring motor carriers to transport and distribute fuel, equipment and other essential goods to communities across the state; and

WHEREAS, the safety and welfare of the residents of affected areas may require the rapid identification of an emergency situation that necessitates the need to suspend state enforcement of federal commercial vehicle and driver laws; and

WHEREAS, Section 390.23 of Title 49, Code of Federal Regulations, provides that a Governor of a state, or the Governor's authorized representatives having authority to declare emergencies, may declare an emergency thereby exempting motor carriers or drivers operating a commercial vehicle from the Federal Motor Carrier Safety Regulations, Parts 390-399, both while providing assistance to the relief efforts during the emergency and while returning empty to the motor carrier's terminal or driver's normal work-reporting location; and

WHEREAS, it is imperative that the State's response to emergency situations involve the seamless coordination between numerous state agencies; and

WHEREAS, the State Emergency Management Agency within the Department of Public Safety is tasked with coordinating the State's response efforts during emergencies; and

WHEREAS, a coordinated and efficient analysis and response to situations requiring an emergency declaration exempting motor carriers and drivers operating a commercial vehicle from the Federal Motor Carrier Safety Regulations and relevant state regulations is best provided by designating the Director of the Department of Public Safety as the Governor's authorized representative to declare such emergencies.

NOW THEREFORE, I, JEREMIAH W. (JAY) NIXON, 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 order as follows:

1. The Director of the Missouri Department of Public Safety or the Director's designee is authorized to issue an emergency declaration of a regional emergency within the meaning of 49 CFR section 390.23(a)(1) or a local emergency within the meaning of 49 CFR section 390.23(a)(2) for the limited purpose of temporarily suspending the usual requirements of Parts 390-399 of Title 49, Code of Federal Regulations, with reference to motor carriers and operators of commercial motor vehicles, when such official determines that an emergency situation exists which requires the suspension of federal commercial motor vehicle and driver laws. An emergency declaration issued pursuant to this order shall not exceed the duration of the motor carrier's or driver's direct assistance in providing emergency relief, or five days from the date of the initial declaration of the emergency, whichever is less; and

2. The Missouri Department of Transportation will provide all necessary assistance to the Missouri Department of Public Safety in the assessment of relevant motor carrier and commercial motor vehicle requirements that should be waived pursuant to an emergency declaration; and

3. The Director of the Missouri Department of Public Safety or the Director's designee shall notify the Governor's office as soon as possible of any emergency declarations issued pursuant to this Executive Order; and

4. In order to facilitate an orderly implementation of this Executive Order, the provisions of Executive Order 07-01 as extended by Executive Order 08-40 shall remain in effect until February 1, 2010 at which time they will be superseded by the provisions of this Executive Order.

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 31st day of December, 2009.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Robin Carnahan
Secretary of State