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SALUS POPULI SUPREMA LEX ESTO

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

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

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

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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.

Title 14—DEPARTMENT OF CORRECTIONS
Division 80—State Board of Probation and Parole
Chapter 3—Conditions of Probation and Parole

PROPOSED AMENDMENT

14 CSR 80-3.010 Conditions of Probation and Parole. The division is amending sections (1) through (10) and adding sections (11) through (13).

PURPOSE: This amendment clarifies the conditions of supervision, provides current contact information for the Missouri Board of Probation and Parole, and incorporates by reference the ***Rules and Regulations Governing The Conditions Of Probation, Parole, and Conditional Release****, revised December 2009.*

PUBLISHER'S NOTE: The division has determined that the publication of the entire text of 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.

(1) The first condition reads, "*[Laws]* **LAWS**: I will obey all the federal and state laws, municipal and county ordinances. I will report all arrests to my probation and parole officer within forty-eight (48) hours." *[All of us are expected to obey the laws. If a parolee, or probationer is arrested at any time for any reason, s/he must report his/her arrest to his/her probation and parole officer within forty-eight (48) hours.]*

(2) The second condition reads, "*[Travel]* **TRAVEL**: I will obtain advance permission from my probation and parole officer before leaving the state or the area in which I am living." *[The probation and parole officer must always know where his/her clients are. It will be the probation and parole officer who will determine the area in which the probationer or parolee will be allowed to travel. There may be times when a probationer or parolee will be living in one (1) community and working in another. When this does occur, the probation and parole officer usually limits the area of travel to these two (2) communities. There may be other exceptions from time-to-time which should be discussed with the officer. When the request is reasonable, the officer will allow the probationer or parolee to travel based on a written travel permit for each occasion or without getting his/her permission each time. This will generally depend on the circumstances. If the probationer or parolee travels outside Missouri, there are certain regulations and requirements that must be followed. A travel permit will have to be issued to the probationer or parolee by the probation and parole officer. Since there is a certain amount of paper work involved in preparing these travel permits, the probationer or parolee should discuss his/her travels with his/her probation and parole officer far enough in advance to allow time for the proper paper work to be prepared. Travel permits for travel outside Missouri may be issued on short notice only in case of emergency, such as serious illness or death in the family.]*

(3) The third condition reads, "*[Residency: I will notify my probation and parole officer of any changes of residency within forty-eight (48) hours." Since the probation and parole officer is at all times responsible for knowing his/her clients. place of residence, it is essential for probationers and parolees to notify their officer within forty-eight (48) hours of any change they must make in regard to where they are living. The officer may need to contact a client for some reason or may be planning to stop by the client's home for a visit. This condition is an effort to keep the probationer or parolee and the probation and parole officer in close touch with each other.]* **RESIDENCY: I will obtain advance permission from my probation and parole officer before making any change in residency.**

(4) The fourth condition reads, "*[Employment]* **EMPLOYMENT**: I will maintain employment unless engaged in a specific program approved by my probation and parole officer. I will obtain advance permission from my probation and parole officer before quitting my job or program. In the event I lose my job or am terminated from a program, I will notify my probation and parole officer within forty-eight (48) hours." *[Changing or quitting a job is always a major decision in anyone's life. It is a decision that a probationer or parolee needs to discuss with his/her probation and parole officer before finally deciding what to do. The probation and parole officer can point out the advantages and disadvantages of making the job change. There are many times when a decision of this kind is made on the spur of the moment and without too much thought. One (1) of the main purposes of this rule, therefore, is to help the probationer or parolee to avoid making a decision which s/he may well regret later on by not being able to find another job quickly. Most of us are expected to support ourselves, have a family to support or debts to pay. It is a normal expectation that these obligations be met. This is no different for a person under supervision than it is for any other citizen. We have found over the years that involvement in criminal behavior and unemployment are closely related. During the supervision period a probationer or parolee will be expected to maintain employment. The only excuse from this obligation will be his/her involvement in a specific program such as vocational training, drug or alcohol abuse treatment or other programs related to his/her self improvement. A probationer or parolee must remember that before quitting or changing a job or program, s/he must have advance permission from his/her probation and parole officer. In the event a probationer or parolee is fired from a job or program, s/he has the obligation to notify his/her probation and parole officer within forty-eight (48) hours.]*

(5) The fifth condition reads, "*[Association: I will not associate with any person who has been convicted of a felony or misdemeanor." As a probationer or parolee reviews his/her past life and thinks about how s/he got involved in difficulty with the law, many times the probationer or parolee will have to admit that his/her association with some other person who previously had been in difficulty, played a role in his/her situation. This condition is to help probationers and parolees avoid this mistake in the future. It will be the probationer's or parolee's responsibility to know with whom s/he associates. We would caution probationers and parolees to select their friends and associates wisely. Naturally there will be times when a probationer's or parolee's work and place of residency will place him/her in contact with persons who have been convicted of felonies and misdemeanors. The mere fact that the probationer or parolee lives in the same rooming house or works in the same place of employment does not mean that s/he has to associate after working hours or outside the place of residence. If because of place of residency or employment the probationer or parolee finds him/herself in association with someone who has been convicted, s/he should advise his/her probation and parole officer of the circumstances.]* **ASSOCIATION: I will obtain advance permission from my probation and parole officer before I associate with any person convicted of a felony or misdemeanor,**

or with anyone currently under the supervision of the Board of Probation and Parole. It is my responsibility to know with whom I am associating.

(6) The sixth condition reads, "*[Drugs]* **DRUGS**: I will not have in my possession or use any controlled substance except as prescribed for me by a licensed medical practitioner." *[Use of any controlled substance unless prescribed by a physician is illegal. Therefore, the use or possession of drugs is not only a violation of his/her probation and parole conditions but is also a violation of the law.]*

(7) The seventh condition reads, "*[Weapons: I will, if my probation or parole is based on a misdemeanor involving firearms or explosives, or any felony charge, not own, possess, purchase, receive, sell or transport any firearms, ammunition or explosive device or any dangerous weapon as defined by federal, state or municipal laws or ordinances." If a probationer is a misdemeanor offender and the misdemeanor for which s/he is now on probation did not involve firearms or explosives then s/he is excluded from the condition, unless for other reasons his/her probation and parole officer, the parole board or the court, feel that it is pertinent to his/her success under supervision. Then they may invoke this condition as a special condition of his/her probation or parole. This condition does apply to any individual who has been convicted of a misdemeanor that relates to or involves firearms or explosives and to all individuals who are on probation or parole as a result of a felony conviction. The Federal Firearms Act will cause this condition of restrictions on firearms past the end of a probation or parole period. As it stipulates, it is illegal for a person to have a firearm if s/he has been convicted of a misdemeanor involving firearms or explosives or any law of the state punishable by a term of imprisonment of two (2) years or more. At the time of a probationer or parolee's discharge from probation or parole, s/he should consult with his/her probation and parole officer as to how to obtain relief through the Department of Treasury, Bureau of Alcohol, Tobacco and Firearms Division to the restrictions placed upon the probationer or parolee regarding his/her possession and use of firearms.]* **WEAPONS: I will not own, possess, purchase, receive, sell, or transport any firearms, ammunition, or explosive device, or any dangerous weapon if I am on probation or parole for a felony charge or a misdemeanor involving firearms or explosives, or if it is in violation or federal, state, or municipal laws or ordinances.**

(8) The eighth condition reads, "*[Reporting/Directives]* **REPORTING/DIRECTIVES**: I will report as directed to my probation and parole officer. I *[agree to]* **will** abide by any directives given me by my probation and parole officer." *[The probation and parole officer may have a probationer or parolee report to him/her in a number of different ways, such as his/her personal appearance at his/her office or some other designated place from time-to-time or to send in a monthly supervision report at a designated time. As part of a probationer's or parolee's reporting, s/he may request that s/he bring documents such as check stubs, receipts for restitution or court costs, receipts for installment payments, income tax forms, all of which will be helpful to the officer in planning with the probationer or parolee towards a successful parole and probation period. If the probationer or parolee tries to contact his/her probation and parole office by telephone and s/he is not in at the time of the call, the probationer or parolee must identify him/herself to someone in the office and tell why s/he is calling and why s/he wants to see his/her probation and parole officer. In this way the person at the office can inform the probation and parole officer of the call or the probationer or parolee's wish to see him/her. The probation and parole officer can then get in touch with the probationer or parolee as soon as s/he is able to do so. The officer from time-to-time may give the probationer or parolee special directives that will relate to him/her as an individual. This may not be a condition of the probation or parole as specified on that document; however, they still may be directives that have an important impact as the probationer or parolee and his/her officer plan together for the probationer's or parolee's future. For example, if the probationer or parolee decides to marry, it is advisable for him/her to consult with his/her probation and parole officer and obtain his/her advice and suggestions in this regard. The probation and parole officer may very well wish to interview the probationers or parolees prospective marriage partner in order to make sure that there are no legal barriers to the marriage or misunderstanding between the two (2) of them that might cause difficulty in the marriage at a later date. Obviously, no probationer or parolee is allowed to live in a common law relationship since it is not legal in this state. If a probationer or parolee is living in such a relationship at the time s/he is placed on probation, it will be the responsibility of the probation and parole officer to work with him/her and his/her common law spouse towards consummating the relationship by marriage. Another directive could regard installment buying of some type. Buying a particular item on installments is very easy to do but installment payments are not always easy to make. To help a probationer or parolee avoid getting into financial difficulty, s/he should discuss installment purchasing with his/her probation and parole officer.]*

(9) The ninth condition reads, "*[Special Conditions." Both the Division of Probation and Parole and the court that has placed a person on probation have the authority to determine special conditions of probation or parole supervision. Depending on the circumstances of the situation, special conditions may include things such as prohibiting a probationer or parolee from consuming alcoholic beverages, requiring him/her to stay in a halfway house for a certain period or requiring him/her to be involved in an educational-vocational training program. Special conditions may also set out certain restrictions that are placed upon a probationer or parolee if s/he is released for medical or mental treatment. Special conditions are frequently used for setting court costs, fines and restitution. On occasion they will be used to require that the probationer or parolee not visit a specific location or area. These are but examples of special conditions that may be imposed and they certainly are not limited to the previously mentioned list. They are as important as any of the preceding eight (8) conditions of probation and parole and failure to abide by any special condition as stated on an order will be considered a violation of probation or parole.]* **SUPERVISION STRATEGY: I will enter and successfully complete any supervision strategy and abide by all rules and program requirements, as directed by the court, board, or my supervising probation and parole officer.**

(10) *[Location of the central office of the Board of Probation and Parole (where the board members can be found), field probation and parole offices and institutional parole offices are as follows:*

(A) Central office is at 211 Marshall, Jefferson City;

(B) Field offices are in St. Joseph, Chillicothe, Hannibal, Kansas City (two (2) locations), Warrensburg, Columbia, St. Louis City (four (4) locations), St. Louis County (two (2) locations), Carthage, Springfield, Rolla, Farmington, West Plains, Sikeston, Hillsboro, Union, St. Charles, Macon, North Kansas City, Camdenton, Branson, Cape Girardeau, Kennett,

Independence, Poplar Bluff, Fulton, Jefferson City and Grandview; and

(C) Institutional parole offices are at the state penitentiary in Jefferson City, the Algoa correctional center near Jefferson City, the central Missouri correctional center near Jefferson City, the training center at Moberly, the correctional center at Pacific and the Boonville correctional center.] **The tenth condition reads, "INTERVENTION FEE: I shall pay a monthly intervention fee in an amount set by Missouri Department of Corrections pursuant to section 217.690, RSMo. This payment shall be due and payable on the first day of the first month following placement on probation, or acceptance of an interstate case in the state of Missouri or on the first day of the fourth month following parole, or conditional release."**

(11) The eleventh condition reads, "SPECIAL CONDITIONS: Both the Board of Probation and Parole and the court that has placed you on probation, parole, or conditional release have the authority to determine special conditions of your supervision period."

(12) The central office of the Missouri Board of Probation and Parole (where the board members can be found) is located at 3400 Knipp Drive, Jefferson City, Missouri, 65109.

(13) The *Rules and Regulations Governing the Conditions of Probation, Parole, and Conditional Release*, revised December 2009, is hereby incorporated by reference in this rule as published by the Board of Probation and Parole and is available at 3400 Knipp Drive, Jefferson City, Missouri, 65109. This rule does not incorporate any subsequent amendments or additions.

*AUTHORITY: sections 217.690 and 217.755, RSMo [1986 and 217.690, 2006.] **Supp. 2010.** This rule was previously filed as 13 CSR 80-3.010. Original rule filed Feb. 5, 1968, effective Feb. 15, 1968. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 19, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Probation and Parole, Kim Jones-Drury, 3400 Knipp Drive, Jefferson City, MO 65109 or by email at kim.jones-drury@doc.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 14—DEPARTMENT OF CORRECTIONS
Division 80—State Board of Probation and Parole
Chapter 3—Conditions of Probation and Parole

PROPOSED RULE

14 CSR 80-3.020 Conditions of Lifetime Supervision

PURPOSE: This rule sets forth conditions of supervision for those placed on lifetime supervision after their terms for a probation, parole, conditional release, or prison sentence have been completed.

(1) The first condition reads, "LAWS: I will obey all the federal and state laws, municipal and county ordinances. I will report all arrests to my lifetime supervision officer as soon as possible."

(2) The second condition reads, "GLOBAL POSITIONING SATELLITE MONITORING (GPS): I will abide by the requirements of GPS supervision including maintaining a residence that allows for this supervision to occur."

(3) The third condition reads, "INTERVENTION FEE: I shall pay a monthly intervention fee in an amount set by Missouri Department of Corrections pursuant to section 217.690, RSMo. This payment shall be due and payable on the first day of the first month following placement on lifetime supervision."

AUTHORITY: sections 217.735, 217.755, and 559.106, RSMo Supp. 2010. Original rule filed Oct. 19, 2011.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Board of Probation and Parole, Kim Jones-Drury, 3400 Knipp Drive, Jefferson City, MO 65109 or by email at kim.jones-drury@doc.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 14—DEPARTMENT OF CORRECTIONS
Division 80—State Board of Probation and Parole
Chapter 5—Intervention Fee

PROPOSED AMENDMENT

14 CSR 80-5.010 Definitions for Intervention Fee. The division is amending subsection (1)(C).

PURPOSE: This amendment modifies definition of waiver used in this chapter.

(1) For the purpose of 14 CSR 80-5*[:]*—

(C) The term "waiver" means an offender is temporarily relieved of an obligation to pay all or part of the intervention fee, based on the offender's confinement, program involvement, or income, as authorized by the supervising officer and the *[district administrator]* **Chief Administrative Officer (CAO)/designee**;

*AUTHORITY: sections 217.040, **217.690,** and 217.755, RSMo [2000 and section 217.690, RSMo Supp. 2007] **Supp. 2010.** Emergency rule filed Oct. 6, 2005, effective Nov. 1, 2005, expired April 29, 2006. Original rule filed Oct. 6, 2005, effective April 30, 2006. Amended: Filed Aug. 1, 2008, effective Jan. 30, 2009. Amended: Filed Oct. 19, 2011.*

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

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

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Title 14—DEPARTMENT OF CORRECTIONS
Division 80—State Board of Probation and Parole
Chapter 5—Intervention Fee

PROPOSED AMENDMENT

14 CSR 80-5.020 Intervention Fee Procedure. The division is amending paragraphs (1)(I)1. and 2.

PURPOSE: This amendment redefines the designated collection agency in the process for sanctions regarding nonpayment.

(1) The following procedures apply to the collection of an offender intervention fee.

(I) The following process for sanctions regarding nonpayment shall be applied:

1. The designated *[collection]* agency is responsible for collecting payments of the intervention fee;

2. Upon receiving notification from the designated *[collection]* agency that an offender has failed to submit the intervention fee, the supervising officer will remind the offender of the payment obligation during their next contact;

3. The supervising officer should direct the offender to specific programs or services that will assist him/her in addressing their inability to pay (i.e., financial management program, employment counseling and/or job seeking classes, substance abuse counseling, mental health counseling, etc.);

4. When willful nonpayment occurs over a period of ninety (90) consecutive days, the supervising officer shall submit a notice of citation or violation report;

5. Offenders who are not current on their intervention fee payments may not be eligible for transfer to minimum supervision, interstate transfer, or early discharge consideration;

6. Sanctions for willful nonpayment of intervention fees include, but are not limited to the following:

A. Written reprimand from district administrator or parole board;

B. Travel restriction;

C. Community service;

D. Increased level of supervision; and

E. Shock detention;

7. Unpaid intervention fees owed by offenders committed to the Division of Adult Institutions (DAI) will be collected from the inmate's account; and

8. All intervention fees collected by the department will be deposited in the inmate fund established in section 217.430, RSMo, with expenditures occurring as authorized through the state budget appropriation process.

AUTHORITY: sections 217.040, ***217.690,*** *and 217.755, RSMo [2000 and section 217.690, RSMo Supp. 2007]* ***Supp. 2010****. Emergency rule filed Oct. 6,2005, effective Nov. 1, 2005, expired April 29, 2006. Original rule filed Oct. 6, 2005, effective April 30, 2006. Amended: Filed Aug. 7, 2006, effective Feb. 28, 2007. Amended: Filed Aug. 1, 2008, effective Jan. 30, 2009. Amended: Filed Oct. 19, 2011.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Probation and Parole, Kim Jones-Drury, 3400 Knipp Drive, Jefferson City, MO 65109 or by email at kim.jones-drury@doc.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 15—ELECTED OFFICIALS
Division 30—Secretary of State
Chapter 200—State Library

PROPOSED AMENDMENT

15 CSR 30-200.010 State and Federal Grants—Definitions. The State Library is amending subsection (2)(C), adding a new subsection (2)(G), and relettering subsequent subsections accordingly.

PURPOSE: This amendment removes the definition of library advisory committee, adds new definitions for library consortium and the secretary's council on library development and renumbers remaining subsections.

(1) As used in 15 CSR 30-200.010 to 15 CSR 30-200.030, the following terms shall mean:

(C) *[Library advisory committee is a committee established by the secretary of state made up of representatives from all areas of the state which may include legislators, public library trustees, citizens, and librarians from all types of libraries. This committee advises the state librarian and the secretary of state on statewide library concerns, federal grant programs, state aid to public libraries, and all matters that relate to Missouri libraries and library service to Missouri citizens; recommends policy and programs; and communicates the value of libraries to people in the state and to those responsible for libraries]* **Library consortium is any local, statewide, regional, interstate, or international cooperative association of library entities which provides for the systematic and effective coordination of the resources of school, public, academic, and special libraries and information centers and for improved services for the clientele of such library entities**;

(G) Secretary's Council on Library Development is a committee established by the secretary of state made up of representatives from all areas of the state which may include legislators, public library trustees, citizens, and librarians from all types of libraries. This committee advises the state librarian and the secretary of state on statewide library concerns, federal grant programs, state aid to public libraries, and all matters that relate to Missouri libraries and library service to Missouri citizens; recommends policy and programs; and communicates the value of libraries to people in the state and to those responsible for libraries;

*[(G)]***(H)** Special library is a library established by an organization and designed to serve the special needs of its employees or clientele; and

*[(H)]***(I)** State aid to public libraries is a sum appropriated by the legislature for distribution among the public libraries of the state as specified in section 181.060, RSMo *[(1994)]* **2000**.

AUTHORITY: section[s] 181.021, RSMo Supp. [1996] ***2010*** *and* ***section*** *181.060, RSMo [1994]* ***2000****. Emergency rule filed Nov. 18, 1996, effective Nov. 28, 1996, expired May 26, 1997. Original rule filed Nov. 18, 1996, effective May 30, 1997. Amended: Filed Oct. 31, 2011.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or opposition to this proposed amendment by email to brenda.alleebates@sos.mo.gov, by fax to (573) 751-3612, or in writing to Brenda Allee-Bates, Missouri State Library, PO Box 387, Jefferson City, MO 65102-0387. To be considered, comments must be in writing and must be received within thirty (30) days after publication in the ***Missouri Register****. No public hearing is scheduled.*

Title 15—ELECTED OFFICIALS
Division 30—Secretary of State
Chapter 200—State Library

PROPOSED AMENDMENT

15 CSR 30-200.020 State *and Other* Grants-in-Aid. The State Library is amending the rule title, purpose, subsections (2)(A), (2)(B), (3)(A), (3)(B), (3)(F), (4)(A), (4)(B), (4)(C), (4)(E), (6)(B), (7)(A), (7)(B), and paragraphs (4)(D)3., and (4)(E)1.; is deleting paragraphs (4)(E)2., and (4)(E)3., and section (5); and renumbering sections (6) and (7).

PURPOSE: This amendment adds language relating to tax funds for libraries, changes the date for filing certification documentation with the state library, clarifies the process for state aid to newly established libraries, specifies how eligibility may be determined for libraries receiving directed distribution of funds, how applications for aid will be reviewed, clarifies the grant period and payment schedule, how interest must be applied for grant funds, competitive bid requirements, requests for extension of grant period, budget changes, and project modifications.

PURPOSE: This rule establishes eligibility requirements and procedures for the administration of state ***and other types of*** *grants-in-aid appropriated to the state library for the improvement of library services, including state aid for public libraries. These funds are administered by the state librarian under the direction of the secretary of state.*

(2) Each of the following requirements must be met for participation in state grants-in-aid:

(A) A public library must be legally established according to the provisions of Chapter 182, RSMo *[(1994), as amended]*, or other laws of the state related to libraries;

(B) A public library must receive from tax funds an amount equal to ten cents per one hundred dollars (10¢:$100) assessed valuation authorized in accordance with the applicable provisions within Chapter 182*[,]* or section 137.030, RSMo *[1994, as amended]*. A city library which is not supported by a library tax must receive an appropriation from the city of an amount equal to ten cents per one hundred dollars (10¢:$100) assessed valuation. The requisite funds must be assessed and levied, or **in the case of a city library not supported by a library tax,** otherwise *[appropriated in the case of a city library not supported by a library tax,]* **expended,** for the **fiscal** year preceding that in which the grant is made. No grant shall be affected because of a reduction in the rate of levy which is required by the provisions of section 137.073, RSMo *[1994, as amended]* **or because of a voluntary reduction in the levy following the enactment of a district sales tax under section 182.802, RSMo, if the proceeds from the sales tax equal or exceed the reduction in revenue from the levy**;

(3) Per Capita Grants of State Aid for Public Libraries.

(A) During each fiscal year, the state librarian will distribute to eligible public libraries on a per capita basis at least fifty percent (50%) of all moneys appropriated by the general assembly as state aid to public libraries, the allocation of which shall be made in accordance with section 181.060.2, RSMo *[1994, as amended]*.

(B) All eligible public libraries shall file the certification required by section 181.060.3, RSMo *[1994, as amended]*, with the state library no later than *[June 30]* **July 31** of each year. The state library will provide certification forms with instructions to all public libraries annually and upon request.

(F) Per capita state aid grants will be remitted to all certified libraries *[in quarterly payments]*.

(4) Other Grants of State Aid To Public Libraries Under Section 181.060, RSMo.

(A) For each fiscal year, the state librarian, in *[his/her]* **his or her** discretion, shall administer and supervise grants to public libraries of the balance of all moneys appropriated by the general assembly pursuant to, in accordance with, and for the purposes set forth in section 181.060.4, RSMo *[1994, as amended]*.

(B) State aid grants to newly established library districts *[will]* **may** be made in accordance with the certification process in section 181.060.4, RSMo *[1994, as amended]*.

(C) For appropriations which designate a directed distribution of funds to libraries which meet specific eligibility criteria, the state library will solicit information from the libraries to determine which ones are eligible for participation. **Alternatively, eligibility may be determined by using published data from various sources including state and federal agencies.**

(D) For appropriations for which the funds are awarded on a competitive basis, the following application process will be used:

1. Applications must be submitted in the form and manner prescribed by the state library*[,]* and must include all required signatures;

2. Applications shall include the following information, at a minimum. Additional information and supporting documentation may be requested as appropriate to the type of applications:

A. Description of the project that includes the benefit to be provided to users of the library, project goals, action plan, and a schedule of implementation;

B. Staffing level and expertise sufficient to accomplish the project;

C. Project budget, including specification of any required local matching funds;

D. Indication that the project can be completed within the specified grant period; and

E. Plan for the evaluation of the project;

3. All applications will be examined by state library staff for completeness, compliance with regulations and eligibility criteria, and adherence to instructions. **Applications may also be examined by a review committee composed of representatives from libraries and other appropriate institutions or agencies.** Requests to the applying library for additional information or verification of information must be responded to within the time frames specified by state library staff. Completeness, compliance with regulations and eligibility criteria do not obligate the state librarian or the secretary of state to award any grant. However, applications that are incomplete, substantively inaccurate, or received after the deadline shall be rejected; and

4. The state librarian shall review the applications*[,]* and provide the secretary of state with recommendations for grant awards. The secretary of state shall make the final ruling on funding of specific applications. Applications may be granted in whole or in part.

(E) Grant Period **and Payment Schedule**.

1. The grant period *[begins and ends on the dates specified in the grant letter. Grants must be completed within the fiscal year (July 1 to June 30) in which the grant is awarded]* **and**

payment schedule are specified in the award packet. Grant moneys may take longer to issue than the official grant *[notification letter]* **packet**. While the grantee cannot charge expenses incurred before the grant period begins, appropriate charges incurred after the grant period begins but before the moneys are available, are allowed.

[2. Grantees receiving twenty thousand dollars ($20,000) or less shall receive seventy percent (70%) of the grant funds as soon after the awarding of the grant as practicable. The remaining thirty percent (30%) of the grant shall be paid to the grantee after successful project completion and submission of all required reports.

3. Grantees receiving more than twenty thousand dollars ($20,000) shall receive a first payment of thirty-five percent (35%) as soon as practicable after the awarding of the grant. A second payment of thirty-five percent (35%) shall be made after one-third (1/3) of the project completion is verified through an interim report; with the remaining thirty percent (30%) paid upon successful project completion and submission of all required reports.

(5) Appeal Procedures.

(A) Any library denied funding may inform the state library in writing of its intent to seek a hearing. This letter of intent must be received by the state library within fifteen (15) days following notice of the funding decisions.

(B) The state library shall convene a meeting of an independent committee to consider the library's appeal. The state library, the appellant, and the president of the Missouri Library Association or his/her designee shall each choose one (1) person to serve on the committee.

(C) Unless extended by written agreement of the state library and the appellant, the appeals committee shall meet no later than fifteen (15) days following the receipt of the appeal by the state librarian. The appellant library and the state library may, but need not, be represented by counsel and may, through staff, appear before the committee to testify.

(D) The committee shall make written recommendation to the secretary of state regarding the appeal. The decision of the secretary of state is final.]

*[(6)]***(5)** Audit Requirements.

(A) Grantees must comply with the audit requirements set forth in Missouri statutes for local governmental units. The grantee is responsible for ensuring that the state library receives copies of the audit report in a timely fashion.

(B) Specific accounting requirements for competitive grants awarded under the state aid to public libraries and state grants-in-aid programs are—

1. Grant money must be deposited in an auditable *[interest-bearing]* account *[and interest must be applied to the project]***. When grant funds are deposited in an interest-bearing account, all interest over one hundred dollars ($100) must be applied to the project**;

2. Grant work will be monitored in progress. State library staff may visit the project site(s) for review at any time during the grant cycle;

3. The grantee must submit *[an interim]* report**(s)** on the grant project, *[in]* **by the date and using** the form**(s)** provided by the state library. The report shall *[include a narrative of]* **indicate the** work completed, and **include** a financial status report;

4. Any items or services purchased by the grantee *[in excess of three thousand dollars ($3,000) must be competitively bid and require the solicitation of at least three (3) bids. If three (3) bids are not received, proof of bid solicitation is sufficient]* **must conform to the competitive bid requirements of section 34.040, RSMo**. Proof of bid solicitation on all such items must be submitted with the financial reports;

5. Projects using in-kind contributions as local matches will need to *[submit]* **include** appropriate proof (for example, records of hours worked), with the financial reports;

6. *[Any changes in the project, including changes in budget allocations and project director, must be requested in advance in writing to the state library]* **Requests for extension of the grant period, budget changes, or other modifications to the project shall be made in writing to the state library no later than three (3) weeks prior to the end of the grant period. The state librarian may, at his or her discretion, allow an amendment subject to the appropriation and availability of funds**;

7. In the event of default on the grant project by the grantee, the grant will be revoked and all funds must be returned to the state library. The grantee will be notified by letter by the state library and will receive thirty (30) days*[']* written notice of noncompliance before the grant is revoked; and

8. The grantee shall prepare a final report on the grant project. Forms will be provided for both segments of the final report, 1) project summary and evaluation and 2) final financial report.

*[(7)]***(6) Federal and** Other **Types of** Grants to Libraries. Unless otherwise expressly provided for, any appropriations made by the general assembly other than appropriations made under section 181.060, RSMo**,** with respect to which the state library is designated as the administering agent shall be distributed pursuant to applications or requests for proposals governed to the greatest degree practicable by the procedures set forth in sections (4) through (6) hereinabove with the following exceptions:

[(A) Applications for appropriations of funds awarded on a competitive basis will be reviewed by an independent committee appointed by the state librarian. Committee members may include, but are not limited to, members of the library advisory committee and representatives of the library community. The independent committee shall receive copies of all eligible applications and selection criteria prior to the review meeting. The independent committee shall evaluate each application and make its recommendations on funding. The state librarian shall review the committee recommendations, and provide the secretary of state with recommendations for grant awards. The secretary of state shall make the final ruling on the applications to be funded; and

(B) The state librarian may, in his/her discretion, allow extensions for grant project completion, subject to the appropriation and availability of funds. Requests for extension of the grant period must be made in writing to the state librarian at least one (1) month prior to the end of the grant period.]

(A) Funds received from federal sources will follow the federal statutes and regulations of the program involved in addition to applicable state and local statutes and regulations; and

(B) Funds received from other private or public sources will follow program guidelines and regulations from the funding source in addition to applicable state and local statutes and regulations.

*AUTHORITY: section[s] 181.021, RSMo Supp. [1996] **2010,** [and] **sections** 181.060 **and 182.812(3)**, RSMo [1994] **2000, and section 182.802, HB 161, First Regular Session, Ninety-sixth General Assembly, 2011**. Emergency rule filed Nov. 18, 1996, effective Nov. 28, 1996, expired May 26, 1997. Original rule filed Nov. 18, 1996, effective May 30, 1997. Amended: Filed Oct. 31, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or opposition to this proposed amendment by email to brenda.alleebates@sos.mo.gov, by fax to (573) 751-3612, or in writing to Brenda Allee-Bates, Missouri State Library, PO Box 387, Jefferson City, MO 65102-0387. To be considered, comments must be in writing and must be received within thirty (30) days after publication in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 2—Code of Professional Conduct

PROPOSED AMENDMENT

20 CSR 2030-2.040 Standard of Care. The board is proposing to amend the purpose statement and section (1).

PURPOSE: This rule is being amended to reflect the current edition of the International Building Code, Section 107.

*PURPOSE: This rule provides the recipient and producer of professional architectural, engineering, and/or landscape architectural services assurances that all services are evaluated in accordance with the 2009 edition of the **International Building Code**, Section [106] **107**.*

(1) The board shall use, in the absence of any local building code, Section *[106]* **107** only of the 2009 edition of the *International Building Code*, not including or applying any other sections referenced within Section *[106]* **107**, as the standard of care in determining the appropriate conduct for any professional licensed or regulated by this chapter and being evaluated under section 327.441.2(5), RSMo. The *International Code Council*, 2009 Edition is incorporated herein by reference and may be obtained by contacting 500 New Jersey Ave NW, 6th Floor, Washington, DC 20001, by phone at 1 (888) ICC-SAFE (422-7233), by fax at (202) 783-2348**,** or by their direct website at http://www.iccsafe.org. This rule does not incorporate any subsequent amendments or additions to the manual.

*AUTHORITY: section 327.041, RSMo Supp. [2008] **2010**. Original rule filed June 14, 2007, effective Dec. 30, 2007. Amended: Filed July 22, 2009, effective Jan. 30, 2010. Amended: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 2—Code of Professional Conduct

PROPOSED AMENDMENT

20 CSR 2030-2.050 Title Block. The board is proposing to amend section (1).

PURPOSE: This rule is being amended to include land surveying entities.

(1) An architectural, engineering**, land surveying,** or landscape architectural entity shall incorporate a title block on all drawings and other documents required to be signed and sealed by Chapter 327, RSMo**,** and these regulations.

*AUTHORITY: sections 327.041 **and 327.411**, RSMo Supp. [2006] **2010**. Original rule filed June 14, 2007, effective Dec. 30, 2007. Amended: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 11—Renewals

PROPOSED AMENDMENT

20 CSR 2030-11.015 Continuing Professional Competency for Professional Engineers. The board is proposing to amend section (6).

PURPOSE: This rule is being amended to allow ten (10) professional development hours (PDHs) for obtaining a patent.

(6) Credits. PDHs of credit for qualifying courses successfully completed that offer semester hour, quarter hour, or CEU credit is as specified in this rule. All other activities permit the earning of one (1) PDH of credit for each contact hour with the following exceptions:

(C) Five (5) PDHs are earned for a paper or article that is published in a nationally circulated technical journal or article. Credit cannot be claimed until that article or paper is actually published; *[and]*

(D) A one-time award of ten (10) PDHs will be granted for obtaining a work-related patent; and

*[(D)]***(E)** Notwithstanding the provisions above, PDHs will only be awarded for the first occurrence of attending or teaching a qualifying course or seminar per every two (2)-year renewal period.

*AUTHORITY: section 327.041, RSMo Supp. [2007] **2010,** and section 327.261, RSMo 2000. This rule originally filed as 4 CSR 30-11.015. Original rule filed Nov. 1, 2001, effective June 30, 2002. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 11—Renewals

PROPOSED AMENDMENT

20 CSR 2030-11.035 Continuing Education for Landscape Architects. The board is proposing to add paragraph (4)(A)11.

PURPOSE: This rule is being amended to allow ten (10) continuing education units for obtaining a patent.

(4) Activities.

(A) The following suggested list may be used by all licensed landscape architects in determining the types of activities that may fulfill continuing education requirements:

1. Contact hours in attendance at short courses or seminars, dealing with landscape architectural, architectural, engineering**,** or land surveying subjects, as appropriate to each discipline and sponsored by colleges or universities;

2. Contact hours in attendance at technical presentations on subjects which are held in conjunction with conventions or at seminars related to materials use and function. Such presentations as those sponsored by the Council of Landscape Architectural Registration Boards (CLARB), American Society of Landscape Architects (ASLA), or similar organizations devoted to landscape architectural, architectural, engineering, or land surveying education may qualify;

3. Contact hours in attendance at short courses or seminars, relating to business practice or new technology and offered by colleges, universities, professional organizations, or system suppliers;

4. Contact hours spent in self-study courses sponsored by the CLARB, ASLA**,** or similar organizations;

5. Three (3) units preparing for each class hour spent teaching landscape architectural courses or seminars. Credit is allowed for first occurrence of teaching course or seminar per two (2)-year renewal period. College or university faculty may not claim credit for teaching regular curriculum courses;

6. Contact hours spent in landscape architectural research, which is published or formally presented to the profession or public;

7. College or university credit courses dealing with landscape architectural subjects or business practice. Each semester hour shall equal fifteen (15) CEUs;

8. Contact hours spent in professional service to the public that draws upon the licensee's professional expertise on boards or commissions, such as: serving on planning commissions, park boards, city council, county commissions**,** or state registration boards;

9. Contact hours, maximum of one (1) per annum, spent actively participating in a technical profession society or organization as an officer or member of a committee; *[or]*

10. Contact hours spent in education tours of landscape architecturally significant projects, where the tour is sponsored by a college, university**,** or professional organization*[.]***; or**

11. A one-time award of ten (10) CEUs will be granted for obtaining a work-related patent.

*AUTHORITY: sections 327.041 **and 327.621**, RSMo Supp. [2008] **2010,** and sections 41.946 and 327.171, RSMo 2000. Original rule filed Jan. 15, 2008, effective July 30, 2008. Amended: Filed April 3, 2009, effective Sept. 30, 2009. Amended: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 14—Definitions

PROPOSED RESCISSION

20 CSR 2030-14.050 Definition of Degree in Science as Used in Section 327.391, RSMo. This rule provided a clear definition of the words degree in science as those words are used in section 327.391, RSMo.

PURPOSE: During the 2006 legislative session, the Missouri General Assembly passed HB 1494 and SB 819, which removed degree in science as a qualification for licensure as an engineer or professional land surveyor. This rule is being rescinded since it is no longer applicable.

AUTHORITY: section 327.041, RSMo 1986. This rule originally filed as 4 CSR 30-14.050. Original rule filed Jan. 12, 1984, effective April 12, 1984. Moved to 20 CSR 2030-14.050, effective Aug. 28, 2006. Rescinded: Filed Nov. 1, 2011.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 2—Licensing of Physicians and Surgeons

PROPOSED AMENDMENT

20 CSR 2150-2.150 Minimum Requirements for Reinstatement of Licensure. The board is proposing to amend section (1).

PURPOSE: This amendment would revise the basic minimum requirements that a physician must meet in order to reinstate his/her license after it has been revoked, suspended, or inactive. This amendment removes a reference to two (2) exams that are outdated and adds another option for evaluation at a specialized assessment center in order to ensure that a physician is competent to practice medicine in Missouri.

(1) The board may require each applicant seeking to restore to good standing a license, certificate**,** or permit issued under Chapter 334, RSMo, which has been revoked, suspended**,** or inactive for any reason for more than two (2) years, to present with his/her application evidence to establish the following:

(A) Satisfactorily completing twenty-five (25) hours of continuing medical education courses*[, either]* American Medical Association Category 1**,** *[or]* American Osteopathic Association Category 1A or 2A**, or American Academy of Family Practice Prescribed credit**, for each year during which the license, certificate**,** or permit was revoked, suspended**,** or inactive; and

(B) Successfully-passing, during the revoked, suspended**,** or inactive period, one (1) of the following:

1. *[the]* **The** American Specialty Board's certifying examination in the physician's field of specialization*[,]***;**

2. *[Component 2 of the Federation Licensing Examination (FLEX) before January 1, 1994, Step 3 of the United States Medical Licensing Examination (USMLE) or the]* **The** Federation of State Medical Board's Special Purpose Examination (SPEX)**;**

3. An assessment by the Center for Personalized Physician Education Program (CPEP), 7351 Lowry Boulevard, Suite 100, Denver, CO 80230, the University of California, San Diego, Physician Assessment and Clinical Education Program (PACE), 1899 McKee Street, Suite 126, San Diego, CA 92110, or other agency jointly agreed to by the licensee and the board.

*AUTHORITY: section[s] 334.100.5****, RSMo Supp. 2010,*** *and* ***section*** *334.125, RSMo 2000. This rule originally filed as 4 CSR 150-2.150. Original rule filed Jan. 19, 1988, effective April 15, 1988. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Nov. 1, 2011.*

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

PRIVATE COST: This proposed amendment will cost private entities approximately fourteen thousand four hundred fifty dollars ($14,450) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PRIVATE FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2150 - State Board of Registration for the Healing Arts
Chapter 2 - Licensing of Physicians and Surgeons
Proposed Rule - 20 CSR 2150-2.150 Minimum Requirements for Reinstatement of Licensure
Prepared August 5, 2011 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the amendment by affected entities:
1	CPEP Assessment @ $7,550.00	$7,550.00
1	PACE Assessment @ $6,900.00	$6,900.00
	Estimated Annual Cost of Compliance for the Life of the Rule	**$14,450.00**

III. WORKSHEET

See Table Above

IV. ASSUMPTION

1. The figures reported above are based on FY11 actuals.
2. Skill assessment examination fees are set by the agency and are the responsibility of the applicant.
3. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 3—Licensing of Physical Therapists and Physical Therapist Assistants

PROPOSED AMENDMENT

20 CSR 2150-3.010 Applicants for Licensure as Professional Physical Therapists. The board is proposing to amend section (2).

PURPOSE: This amendment sets forth the requirements for internationally trained applicants as passed in Senate Bill 788 (2008).

(2) The applicant must furnish satisfactory evidence of completion of a program of physical therapy education approved as reputable by the board. If the applicant graduated on or before December 31, 2002, he/she must present evidence that his/her physical therapy degree is the equivalent of a bachelor's degree in physical therapy from a United States college or university. If the applicant graduated after December 31, 2002, he/she must present evidence that his/her physical therapy degree is equivalent in content to the first professional degree in physical therapy in the United States as defined by the Federation of State Boards of Physical Therapy (FSBPT) *[as defined in the Coursework Evaluation Tool for the Evaluation of Foreign Educated Physical Therapist, dated May 2004, which is incorporated herein by reference as published by the FSBPT, or its successor agency, available upon request from this office or upon request from the FSBPT]*, 124 West Street South, Third Floor, Alexandria, VA 22314, (703) 299-3100. *[This rule does not incorporate any subsequent amendments or additions.]* **An internationally trained applicant who graduated on or before December 31, 2002, must have education and training in physical therapy substantially equivalent to a bachelor's degree in physical therapy from a United States college or university. An internationally trained applicant who graduated after December 31, 2002, must have education and training in physical therapy substantially equivalent to the first professional degree in physical therapy in the United States as defined by FSBPT. This includes an assessment of the applicant's general and professional education. Applicants who wish to have their general and professional education considered "substantially equivalent" must submit their credentials to the Foreign Credentialing Commission of Physical Therapy (FCCPT), 124 West Street South, Third Floor, Alexandria, VA 22314 (703) 684-8406. The FCCPT shall use the coursework evaluation tool for foreign educated physical therapists as developed by the FSBPT and evaluate the applicant's credentials against the requirements at accredited physical therapy programs in place at the time of the applicant's graduation.** An applicant who presents satisfactory evidence of graduation from a physical therapy program approved as reputable by the Commission on Accreditation in Physical Therapy Education, or its successor, shall be deemed to have complied with the education requirements of this section.

*AUTHORITY: section 334.125, RSMo 2000, and sections 334.530, **334.540,** 334.550, and 334.687, RSMo Supp. [2008] **2010**. This rule originally filed as 4 CSR 150-3.010. Original rule filed Dec. 19, 1975, effective Dec. 29, 1975. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 1, 2011.*

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

PRIVATE COST: This proposed amendment will cost private entities approximately three thousand two hundred forty-five dollars ($3,245) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2150 - State Board of Registration for the Healing Arts
Chapter 3 - Licensing of Physical Therapists and Physical Therapist Assistants
Proposed Amendment - 20 CSR 2150-3.010 Applicants for Licensure as Professional Physical Therapists
Prepared October 31, 2011 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

First Year of Implementation of Rule

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the rule by affected entities:
11	International Applicants (Educational Evaluation by FCCPT @ $295)	$3,245
	Estimated Biennial Cost of Compliance for the Life of the Rule	**$3,245**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The above figures are based on FY11 actuals.
2. International applicants submit the evaluation fee directly to the Foreign Credentialing Commission of Physical Therapy (FCCPT).
3. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

PROPOSED AMENDMENT

20 CSR 2150-6.010 Definitions. The board is proposing to amend subsections (1)(D), (1)(E), and (1)(F).

PURPOSE: This amendment corrects the organization that publishes the Athletic Training Clinical Proficiencies which is listed incorrectly in the existing rule and updates the address of the National Athletic Trainers' Association (NATA).

(1) As used in this rule, unless the context clearly requires otherwise, the following terms mean:

(D) Direct supervision—as defined by the National Athletic Trainers**'** Association Board of Certification**, Inc.** *[(NATA BOC)]* or its successor agency between the athletic trainer licensed pursuant to Chapter 334, RSMo**,** and the *[perspective]* **prospective** applicant;

(E) Certified athletic trainer—an athletic trainer certified by the *[NATA BOC]* **National Athletic Trainers' Association Board of Certification, Inc.** or its successor agency;

(F) Educational quality equal—as defined in *Athletic Training Clinical Proficiencies*, 4th Edition, **November 6, 2009,** which is incorporated herein by reference as published by the *[NATA BOC]* **National Athletic Trainers' Association, Inc.** or its successor agency, available upon request from this office or upon request from the *[NATA BOC, 4223 South 143rd Circle, Omaha, NE 68137-4505]* **National Athletic Trainers' Association Board of Certification, Inc. 2952 Stemmons Freeway #200, Dallas, TX 75247** or its successor agency. This rule does not incorporate any subsequent amendments or additions;

*AUTHORITY: sections 334.125, RSMo 2000, and 334.706.3(2), RSMo Supp. [2004] **2010**. This rule originally filed as 4 CSR 150-6.010. Emergency rule filed April 5, 1985, effective April 15, 1985, expired Aug. 13, 1985. Original rule filed May 3, 1985, effective Aug. 15, 1985. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

PROPOSED AMENDMENT

20 CSR 2150-6.020 Applicants for Licensure as Athletic Trainers. The board is proposing to amend section (4).

PURPOSE: This amendment requires the applicant to provide proof of successful passage of the National Athletic Trainers' Association Board of Certification examination pursuant to section 334.708, RSMo.

(4) *[If the applicant is applying for licensure as an athletic trainer based upon meeting the National Athletic Trainers Association Board of Certification's (NATA BOC's) or its successor agency's certification qualifications, then the applicant shall provide proof that the NATA BOC or its successor agency's certification is current at the time the application is submitted to the board.]* **The applicant shall show evidence of having passed the National Athletic Trainers' Association Board of Certification, or its successor agency, examination by having the agency forward a transcript of the applicant's scores directly to the board.**

*AUTHORITY: section[s] 334.125, RSMo 2000**,** and 334.702, 334.704, 334.706, 334.708, 334.710**,** and 334.712, RSMo Supp. [2006] **2010**. This rule originally filed as 4 CSR 150-6.020. Emergency rule filed April 5, 1985, effective April 15, 1985, expired Aug. 13, 1985. Original rule filed May 3, 1985, effective Aug. 15, 1985. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 1, 2011.*

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

PRIVATE COST: This proposed amendment will cost the National Athletic Trainers' Association Board of Certification, or it successor agency, approximately thirty-five dollars and sixty-four cents ($35.64) annually for the life of the rule and will cost applicants for licensure approximately two thousand twenty-five dollars ($2,025) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

PRIVATE FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2150 - State Board of Registration for the Healing Arts
Chapter 6 - Licensure of Athletic Trainers
Proposed Rule - 20 CSR 2150-6.020 Applicants for Licensure as Athletic Trainers
Prepared October 31, 2011 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated annual increase in revenue associated with the amendment by affected entities:
81	Applicants for Licensure (Transcript @ $25.00)	$2,025.00
	Estimated Annual Cost of Compliance for the Life of the Rule	**$2,025.00**

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the amendment by affected entities:
81	NATABOC or successor agency postage (postage @ $.44)	$35.64
	Estimated Annual Cost of Compliance for the Life of the Rule	**$35.64**

III. WORKSHEET

See Table Above

IV. ASSUMPTION

1. The figures reported above are based on FY11 actuals.
2. The cost to produce the NATABOC transcript is paid by the applicant. The NATABOC covers the cost of the postage to mail the certification to the board office.
3. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

PROPOSED AMENDMENT

20 CSR 2150-6.040 Code of Ethics. The board is proposing to amend section (1).

PURPOSE: This amendment refers to the most current version of the National Athletic Trainers' Association Code of Ethics.

(1) The board and the Missouri Athletic Trainer Advisory Committee adopt and incorporate by reference the *[National Athletic Trainers' Association, Inc. (NATA)] Code of Ethics, [4th Edition]* **updated September 28, 2005, published by the National Athletic Trainers' Association, Inc. (NATA), 2952 Stemmons Freeway, Dallas, TX 75247**. A copy of the NATA's *Code of Ethics[, 2952 Stemmons Freeway, Dallas, TX 75247, phone: 214-637-6382]* is retained at the office of the board and is available to any interested person, upon written request, at a cost not to exceed the actual cost of the reproduction. This rule does not incorporate any subsequent amendments or additions.

*AUTHORITY: section[s] 334.125, RSMo 2000, and **section** 334.706.3(2), RSMo Supp. [2004] **2010**. This rule originally filed as 4 CSR 150-6.040. Emergency rule filed April 5, 1985, effective April 15, 1985, expired Aug. 13, 1985. Original rule filed May 3, 1985, effective Aug. 15, 1985. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2150—State Board of Registration for the Healing Arts
Chapter 6—Licensure of Athletic Trainers

PROPOSED AMENDMENT

20 CSR 2150-6.062 Late Registration and Reinstatement. The board is proposing to delete section (6) and renumber the remaining sections accordingly.

PURPOSE: This amendment removes the requirement that applicants be actively certified with the National Athletic Trainers' Association pursuant to section 334.708, RSMo.

[(6) All applicants shall be actively certified with the National Athletic Trainers' Association.]

*[(7)]***(6)** Applicants whose license has been revoked, suspended**,** or inactive for more than two (2) years shall submit any other documentation requested by the board necessary to verify that the licensee is competent to practice and is knowledgeable of current athletic training techniques, procedures**,** and treatments, as evidenced by continuing education hours, re-examination, or other applicable documentation acceptable and approved by the board pursuant to the provisions of section 334.100.6, RSMo.

*[(8)]***(7)** The board may require an applicant to make a personal appearance before the board and/or committee prior to rendering a final decision regarding license renewal/reinstatement.

*[(9)]***(8)** An applicant may withdraw their application for license anytime prior to the board's vote on the applicant's candidacy for license renewal/reinstatement.

*AUTHORITY: section 334.125, RSMo 2000, and section 334.706.3(2), RSMo Supp. [2007] **2010**. Original rule filed Dec. 5, 2007, effective June 30, 2008. Amended: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2250—Missouri Real Estate Commission
Chapter 4—Licenses

PROPOSED AMENDMENT

20 CSR 2250-4.070 Partnership, Association, or Corporation License. The board is proposing to amend subsection (3)(B).

PURPOSE: This amendment eliminates the requirement to disclose the names and addresses of all unlicensed partners, officers, and associates.

(3) At the time of issuance of a partnership, association**,** or corporation license, the applicant shall make application to the commission on a form approved by the commission which shall include the following:

(B) The name, residence**,** and business addresses of each **Missouri-licensed** partner in a partnership, *[or each]* associate in an association, or *[each]* officer of a corporation*[, licensed or unlicensed]*;

*AUTHORITY: sections **339.010, 339.030, 339.040, 339.080, 339.110,** 339.120, **and 339.160,** RSMo Supp. [2008] **2010**. This rule originally filed as 4 CSR 250-4.070. Original rule filed Nov. 14,*

*1978, effective Feb. 11, 1979. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 27, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Real Estate Commission, PO Box 1339, Jefferson City, MO 65102, by facsimile at (573) 751-2777, or via email at realestate@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2250—Missouri Real Estate Commission
Chapter 7—Schools

PROPOSED AMENDMENT

20 CSR 2250-7.070 General Requirements. The board is proposing to amend section (2), delete section (11), and renumber the remaining sections accordingly.

PURPOSE: This amendment establishes the same requirements for classroom and distance delivery instruction.

(2) For the purpose of the course offerings by accredited real estate schools, an hour means sixty (60) minutes, at least fifty (50) minutes of which shall be devoted to actual *[classroom]* instruction and no more than ten (10) minutes of which shall be devoted to a recess. Times allotted for supervised examinations may be regarded as hours of instruction.

[(11) No approved school may offer more than six (6) hours of continuing education classroom instruction to a student in any one (1) day.]

*[(12)]***(11)** No part of any approved education course shall be used to solicit membership in organizations, recruit licensees for affiliation with any organization**,** or advertise the merits of any organization.

*[(13)]***(12)** Dates, times**,** and location(s) of classroom course offerings must be electronically submitted to the commission at least ten (10) days prior to each course offering. Should changes occur in this information, the school must submit the changes immediately via the reporting method prescribed by the commission.

*[(14)]***(13)** Advertising for an approved distance delivered course shall clearly describe all course requirements that must be met by the licensee/student, including satisfactory completion of a final examination.

*[(15)]***(14)**The student must be physically present in the classroom during one hundred percent (100%) of the actual classroom instruction unless there is good cause as determined by the school and then the school, at its discretion, may allow a student to be absent up to ten percent (10%) of the required hours and still be issued a certificate of attendance. Documentation of duration of absence must be maintained in the school's records.

*[(16)]***(15)** No school shall allow anyone to use the school's premises or classroom to recruit new affiliates for any company one (1) hour before, one (1) hour after, during break periods, lunch periods**,** or during an instruction period, nor shall any school provide lists of students attending classes to any broker for the purposes of recruiting.

*[(17)]***(16)** The school, at the close of any classroom course, shall hand to each individual who has satisfactorily completed the course, a certificate of course completion in a form prescribed by the commission. For licensees who register for the continuing education course on-site without pre-registration, the certificate of course completion must be sent to the licensee within five (5) days of the course completion and the school must have an adequate sign-in/sign-out procedure to ensure attendance and certificate issuance.

*[(18)]***(17)**Within no more than ten (10) days of the completion of a course, the school shall electronically submit to the commission in a format prescribed by the commission, a complete and accurate list of attendees who have satisfactorily completed the course.

*[(19)]***(18)**All courses of study must be taught in adherence to the outline on file with the commission. In the event a substantive change is proposed, the school must file a revised course outline on a form prescribed by the commission at least thirty (30) days in advance of the scheduled course offering. Approval in writing from the commission must be received prior to implementation of any substantive course change. The commission must respond to any proposed changes within twenty (20) days of receipt.

*AUTHORITY: sections 339.045, RSMo 2000**,** and 339.090 and 339.120, RSMo Supp. **[2005] 2010**. This rule originally filed as 4 CSR 250-7.070. Original rule filed April 6, 2006, effective Sept. 30, 2006. Moved to 20 CSR 2250-7.070, effective Aug. 28, 2006. Amended: Filed Oct. 27, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Real Estate Commission, PO Box 1339, Jefferson City, MO 65102, by facsimile at (573) 751-2777, or via email at realestate@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2250—Missouri Real Estate Commission
Chapter 8—Business Conduct and Practice

PROPOSED AMENDMENT

20 CSR 2250-8.030 Branch Offices. The board is proposing to amend section (3).

PURPOSE: This amendment clarifies the allowance for a broker-type licensee to manage more than one (1) office location.

(3) A branch office shall be under the direct supervision of either a licensed broker, broker-salesperson or a broker-partner, broker-associate or broker-officer of the principal licensed broker *[who shall*

devote full time to management of the branch office]; provided that nothing contained in this rule shall be construed to relieve the principal licensed broker from responsibility for all brokerage activities conducted at the branch office. Nothing in this section shall be construed as to prohibit the office manager from engaging in the listing and sale of real estate.

*AUTHORITY: section 339.120, RSMo Supp. [2008] **2010**. This rule originally filed as 4 CSR 250-8.030. Original rule filed Nov. 14, 1978, effective Feb. 11, 1979. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 27, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Real Estate Commission, PO Box 1339, Jefferson City, MO 65102, by facsimile at (573) 751-2628, or via email at realestate@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2250—Missouri Real Estate Commission
Chapter 8—Business Conduct and Practice

PROPOSED AMENDMENT

20 CSR 2250-8.120 Deposits to Escrow or Trust Account. The commission is proposing to amend the purpose statement.

PURPOSE: This rule was previously amended to allow earnest money to be deposited in a noninterest bearing escrow account within ten (10) banking days instead of five (5) banking days. The purpose statement needs to be updated to reflect the same requirements of the rule.

*PURPOSE: This rule requires all earnest money be deposited in a noninterest bearing escrow account not later than [five] **ten (10)** banking days next following the execution of a contract. If the account is interest-bearing, all parties must be made aware. A salesperson must immediately deliver to the broker all money received in connection with a transaction in which s/he is engaged.*

*AUTHORITY: sections **339.100, 339.105,** 339.120, RSMo Supp. [1993] **2010**. This rule originally filed as 4 CSR 250-8.120. Original rule filed Nov. 14, 1978, effective Feb. 11, 1979. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 27, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Real Estate Commission, PO Box 1339, Jefferson City, MO 65102, by facsimile at (573) 751-2777, or via email at realestate@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 1—General Organization

PROPOSED AMENDMENT

22 CSR 10-1.010 General Organization. The Missouri Consolidated Health Care Plan is amending sections (1)–(5).

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

(1) The Missouri Consolidated Health Care Plan *[becomes]* **became** effective January 1, 1994, under an Act of the general assembly. The plan offers health care coverage for state employees, retirees**,** and their dependents. It also provides this benefit as an option to all other public entities within the state, as long as they meet admission criteria that may be established by the board of trustees.

(2) The responsibility for the proper operation of the *[system]* **plan** and the direction of its policies is vested in a board of trustees. The administration of the detailed affairs of the *[system]* **plan** is in the charge of an executive director, aided by *[an assistant executive director]* **a chief operations officer**.

(3) The *[assistant executive director]* **chief operations officer** shall perform duties as may be delegated to him/her by the executive director and in the absence or disability of the executive director shall perform the duties of the executive director.

(4) *[House Bill 1574 of the general assembly of Missouri authorized the establishment of the plan.]* The statutory provisions relating to the establishment and operation of the plan of *[medical]* **health** care benefits is provided for in Chapter 103, RSMo. The rules in 22 CSR 10-2 *[relate to the plan document which]* **and 22 CSR 10-3** delineate*[s]* the terms of the plan established by the trustees of the Missouri Consolidated Health Care Plan *[in accordance with House Bill 1574 and in accordance with Chapter 103, RSMo]*.

(5) Anyone wishing to obtain information may do so by contacting the plan*['s executive director]* at *[any of the following:]*—

(C) (573) 751-8881; *[or]*

(D) (800) 701-8881*[.]***;**

(E) Email: mchcp@mchcp.org; or

(F) Online: www.mchcp.org.

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Dec. 16, 1993, effective July 30, 1994. Amended: Filed Dec. 19, 2003, effective June 30, 2004. Amended: Filed Nov. 1, 2011.

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box

*104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 1—General Organization

PROPOSED AMENDMENT

22 CSR 10-1.020 Public Records. The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

PURPOSE: This amendment changes standards of compliance with Chapter 610, RSMo, as it relates to public records of the Missouri Consolidated Health Care Plan.

(1) All public records of the Missouri Consolidated Health Care Plan, except for those records closed pursuant to the Health Insurance Portability and Accountability Act and section 610.021, RSMo, shall be open for inspection and copying at the plan's office during the plan's regular business hours*[, holidays excepted]*. The plan's regular business hours are 8:30 a.m. until 4:30 p.m., Central *[Standard]* Time. All public meetings**, records, votes, actions, and deliberation** of the Missouri Consolidated Health Care Plan shall be open to the public, other than those meetings**, records, and votes** closed pursuant to provisions of section 610.021, RSMo.

(3) When the custodian determines that requested access is not required under Chapter 610, RSMo, the custodian **upon request** shall inform the requestor of such determination citing the specific sections of Chapter 610, RSMo, under which the records are to remain closed. *[The custodian shall inform the requesting party that s/he may appeal directly to the board for access to the records requested. The appeal and all pertinent information shall be placed on the agenda for the board's next regularly scheduled meeting. If the board reverses the decision of the custodian, the board shall direct the custodian to advise the requestor and supply access to the information during the plan's regular business hours at the requestor's convenience.]*

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Dec. 19, 2003, effective Aug. 30, 2004. Amended: Filed Nov. 1, 2011.

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

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

PROPOSED AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is deleting sections (6), (8), (9), (11), (13), (16), (19), (21), (22), (24)–(26), (29)–(32), (34), (36), (39), (42), (47), (50), (51), (53), (56)–(59), (62), (63), (65)–(67), (71), (75), (78)–(81), (83)–(86), (88)–(90), (93), (96), (99)–(104), (106), (109)–(111), (113), (114), (122), (123), (126), (127), (129), and (132)–(134); amending sections (1), (3)–(5), (9), (10), (14), (18), (23), (27), (28), (33), (37), (38), (40), (41), (43)–(46), (48), (52), (54), (55), (60), (70), (72), (73), (77), (82), (87), (94), (97), (98), (105), (112), (117), (119), (120), (124), (128), and (131); adding sections (9), (22), (24), (30), (45), (47), (56), (71), (73), and (74); and renumbering as necessary.

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

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

(3) Administrative appeal. A written request submitted by or on behalf of a member involving *[Missouri Consolidated Health Care Plan (MCHCP)]* **plan-related** administrative issues such as eligibility, effective dates of coverage, **and** plan changes*[, etc]*.

(4) Adverse **benefit** 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.]* **An adverse benefit determination means any of the following:**

(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;

(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or

(C) Rescission of coverage after an individual has been covered under the plan.

(5) Allowable *[expense]* **amount**. *[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 and coinsurance amounts.]* **Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed. See balance billing, section (7).**

[(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)]***(6)** Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and

functional analysis of the relationship between environment and behavior.

[(8) Assignment. When a doctor agrees to accept Medicare's fee as full payment.]

[(9)] [Benefit period. The three hundred sixty-five (365) days immediately after the first date of services to treat a given condition.]

(7) Balance billing. When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars ($100) and the allowed amount is seventy dollars ($70), the provider may bill the member for the remaining thirty dollars ($30). A network provider may not balance bill.

*[(10)]***(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.]* **Health care services covered by the plan.**

[(11) 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.]

*[(12)]***(9)** Board. The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

[(13) 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.]

*[(14)]***(10)** Cancellation of coverage. The *[voluntary cancellation]* **ending** of medical, dental, or vision coverage per a subscriber's **voluntary** request.

*[(15)]***(11)** Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

[(16) 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.]

*[(17)]***(12)** Claims administrator. An organization or group responsible for the processing of claims and associated services for a health plan.

*[(18)]***(13)** Coinsurance. *[The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.]* **The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars ($100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars ($20). The health insurance or plan pays the rest of the allowed amount.**

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

*[(20)]***(14)** Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

[(21) 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."

(22) 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.]

*[(23)]***(15)** Copayment. *[A set dollar amount that the covered individual must pay for specific services.]* **A fixed amount, for example, fifteen dollars ($15) the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.**

[(24) 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.

(25) Covered benefits and charges. Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.

(26) Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living 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.]

*[(27)]***(16)** Date of service. Date medical services are received *[or performed]*.

*[(28)]***(17)** 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.]* **The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars ($1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollars ($1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.**

[(29) Dependent child. Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:

(A) Stepchild;

(B) Foster child;

(C) Grandchild for whom the employee has legal guardianship or legal custody; and

(D) Other child for whom the employee is the court-ordered legal guardian.

1. Except for a disabled child as described in 22 CSR 10-2.010(89), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six

(26)).

2. A child who is a dependent child under a guardianship of a minor will continue to be a dependent child when the guardianship ends by operation of law when the child becomes eighteen (18) years of age if such child was an MCHCP member the day before the child becomes eighteen (18) years of age.

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

(31) Diagnostic. Describes a procedure to determine whether a person has a particular illness.

(32) 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.]

*[(33)]***(18)** Disease management. A program offered to *[non-Medicare]* members**, who do not have primary Medicare coverage,** to help manage certain chronic diseases.

[(34) Disposable supplies. Supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.]

*[(35)]***(19)** 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) Psychiatrist;

(G) Psychologist;

(H) Doctor of dental medicine, including dental surgery;

(I) Doctor of dentistry; or

(J) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

[(36) 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.]

(20) Effective date. The date on which coverage takes effect as described in 22 CSR 10-2.020(4).

*[(37)]***(21)** Eligibility date. **The first day a member is qualified to enroll for coverage** *[A]***a**s described in 22 CSR 10-2.020**(2)**.

(22) Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.

*[(38)]***(23)** Emergency medical condition. *[A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—*

(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.] **The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:**

(A) 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) With respect to a pregnant woman who is having contractions—

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

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

*[(40)]***(24)** Emergency Services. With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to *[assure]* **ensure**, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

*[(41)]***(25)** Employee. A **benefit-eligible** person employed by the state and present and future retirees from state employment who meet the **plan** eligibility requirements *[as prescribed by law]*.

[(42) Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is eligible as a dependent up to the age of twenty-six (26), except as noted in 22 CSR 10-2.020(1)(A)3.]

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

*[(44)]***(27)** Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care*[/palliative services]*;

(H) Laboratory services—lab and *[x]***X**-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

(28) Excluded services. Health care services that the member's health plan does not pay for or cover.

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

*[(46)]***(30)** Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below **and that the plan administrator determines, in the exercise of its discretion,** 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.

(D) 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.

[(47) 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 eligibility period is the first thirty-one (31) days from the date of the life event.]

*[(48)]***(31)** Formulary. A list of **U.S. Food and Drug Administration approved** drugs *[covered]* **and supplies developed** by the pharmacy benefit manager and *[as allowed]* **covered** by the plan administrator.

*[(49)]***(32)** 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.

[(50) 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.

(51) 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 is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2011 State Member Handbook (March 15, 2011) or online at www.mchcp.org. It does not include any later amendments or additions.]

*[(52)]***(33)** Health assessment (HA). A questionnaire about a member's health and lifestyle habits required for participation in the *[wellness]* **Lifestyle Ladder** program.

[(53) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.]

*[(54)]***(34)** Health savings account (HSA). A tax-advantaged savings account that may be used to pay **for** 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.]*

*[(55)]***(35)** High Deductible Health Plan (HDHP). A health plan with **a** higher deductible*[s]* than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

[(56) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.

(57) Hospice. 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.

(58) 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.

(59) 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 subsection (59)(A) 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.]

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

*[(61)]***(37)** Incident. A definite and separate occurrence of a condition.

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

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

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

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

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

(67) Lifestyle Ladder. MCHCP's wellness program.]

*[(68)]***(39)** Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.

*[(69)]***(40)** MCHCPid. An individual MCHCP member identifier used for member verification and validation.

*[(70)]***(41)** myMCHCP. A secure MCHCP member website that *[includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites]* **allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites**.

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

*[(72)]***(42)** 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 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.

*[(73)]***(43)** Medicare-approved amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a *[doctor or]* **health care** provider.

(44) Medicare assignment. When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.

*[(74)]***(45)** Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

[(75) Network provider. A physician, hospital, pharmacy, or other health provider that is contracted with the plan or its designee.]

(46) Network. The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

*[(76)]***(47)** Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.

*[(77)]***(48)** Non-network *[provider or non-participating provider. A physician, hospital, pharmacy, or other health provider that does not have a contract with the plan or its designee]*. **The facilities, providers, and suppliers the health plan does not contract with to provide health care services.**

[(78) 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.

(79) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients recovering 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 that are recognized under Medicare.

(80) 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.

(81) 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.]

*[(82)]***(49)** Out-of-pocket maximum. *[The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.]* **The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.**

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

(84) 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.

(85) 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 assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

(86) 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; 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.

(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.]

*[(87)]***(50)** Participant. *[Any employee or dependent accepted for membership in the plan.]* **Shall have the same meaning as the term member defined herein. See member, section (45).**

[(88) Pharmacy benefit manager (PBM). The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.

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

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

*[(91)]***(51)** Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

*[(92)]***(52)** Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board 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.

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

*[(94)]***(53)** Plan year. The *[calendar year beginning]* **period of** January 1 through December 31. *[This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.]*

*[(95)]***(54)** Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

(55) Premium. The monthly amount that must be paid for health insurance.

[(96) Preventive service. A procedure intended for avoidance or early detection of an illness.]

*[(97)]***(56)** Primary care physician (PCP). *[A physician (usually a]***An** internist, family/general practitioner, or pediatrician*[) who has contracted with a medical plan]*.

*[(98)]***(57)** 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.]* **A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.**

[(99) Private duty nursing. 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 prior group insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.

(102) 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.

(103) Prostheses. An artificial extension that replaces a missing part of the body or supplements defective parts.

(104) Protected health information (PHI). 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.]

*[(105)]***(58)** Provider. A physician, hospital, medical agency, specialist, or other duly*[-]* licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010*[(35)]***(19)**. Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of *[their]* **his/her** license in the state in which *[they]* **s/he** practice**s** and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Chiropractor;

*[(E)]***(F)** Licensed Clinical Social Worker;

*[(F)]***(G)** Licensed Professional Counselor (LPC);

*[(G)]***(H)** Licensed Psychologist (LP);

*[(H)]***(I)** Nurse Practitioner (NP);

*[(I)]***(J)** Physician*[s]* Assistant (PA);

*[(J)]***(K)** *[Qualified]* Occupational Therapist;

*[(K)]***(L)** *[Qualified]* Physical Therapist;

*[(L)]***(M)** *[Qualified]* Speech Therapist;

*[(M)]***(N)** Registered Nurse Anesthetist (CRNA);

*[(N)]***(O)** Registered Nurse Practitioner (ARNP); or

*[(O)]***(P)** Therapist with a PhD or Master's Degree in Psychiatry or related field.

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

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

*[(108)]***(60)** 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 member if the plan normally provides coverage for dependent children.

[(109) 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.

(110) Refractions. A record of the patient's preference for the focusing of the eyes that may then be used to purchase eyeglasses or contact lenses. It is the part of the exam that determines what prescription lens gives the patient the best possible vision.

(111) 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.]

*[(112)]***(61)** 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*[(7)(B)]***(2)(D)** and is currently receiving a monthly retirement benefit from a retirement system listed in such rule.

[(113) Skilled nursing care. Services that must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.

(114) Skilled nursing facility (SNF). A public or private facility licensed and operated according to the law that provides—

(A) Permanent and full-time facilities for ten (10) or more resident patients;

(B) A registered nurse or physician on full-time duty in charge of patient care;

(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;

(D) A daily medical record for each patient;

(E) Transfer arrangements with a hospital; and

(F) A utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.]

*[(115)]***(62)** 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.

*[(116)]***(63)** 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.

*[(117)]***(64)** Specialty medications. High cost drugs that *[are primarily self-injectible; sometimes oral medications]* **treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis**.

*[(118)]***(65)** State. Missouri.

*[(119)]***(66)** Step therapy. Designed to encourage use of therapeutically*[-]* equivalent, lower-cost alternatives before using 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.

*[(120)]***(67)** 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]* **member** and recover the money directly from the other insurer.

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

[(122) 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.

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

*[(124)]***(69)** Survivor. A member who meets the requirements of subsection 22 CSR 10-2.020*[(7)(A)]***(2)(D)**.

(70) Terminated vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020(2)(D).

*[(125)]***(71)** Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

(72) Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

(73) Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

[(126) 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.

(127) 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.]

*[(128)]***(74)** Usual, *[C]***c**ustomary, and *[R]***r**easonable *[charge]*. **The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.**

[(A) Usual. The fee a provider 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 providers 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 providers for ninety percent (90%) of the procedures reported.

(129) 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.]

*[(130)]***(75)** Vendor. The current applicable third-party administrators of MCHCP benefits.

*[(131)]***(76)** Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020*[(7)(B)]***(2)(D)**.

[(132) Wellness participation year. Year in which members may participate in the wellness program per plan year: October 1–September 25.

(133) Wellness program. A voluntary program focusing on awareness, health education, and behavior change.

(134) Wellness premium. The monthly medical premium applied to members who successfully complete all requirements of the Lifestyle Ladder program.]

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 Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

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

PROPOSED RESCISSION

22 CSR 10-2.020 General Membership Provisions. This rule established the policy of the board of trustees in regard to the General Membership Provisions of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify general membership provisions.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded: Filed Nov. 1, 2011.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

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

PROPOSED RULE

22 CSR 10-2.020 General Membership Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the general membership provisions of the Missouri Consolidated Health Care Plan.

(1) Terms and Conditions. The following rules provide the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). Members are required to provide complete, true, and accurate information to MCHCP in connection with enrollment, change, or cancellation processes, whether by online, written, or verbal communication. MCHCP may rely on, but reserves the right to audit, any information provided by members and seek recovery and/or pursue legal action to the extent members have provided incomplete, false, or inaccurate information.

(2) Eligibility Requirements.

(A) Employee Eligibility Requirements.

1. An employee may enroll in one (1) of MCHCP's plans if s/he meets the following criteria:

A. A state employee whose position is covered by the Missouri State Employees' Retirement System (MOSERS) and not covered under another retirement or benefit plan supported by state contributions or a member of the Public School Retirement System (PSRS) and employed by a state agency.

2. An employee cannot be covered as an employee and as a dependent.

(B) Dependent Eligibility Requirements.

1. An employee who is not retired may enroll eligible dependents as long as the employee is also enrolled. Eligible dependents include:

A. Spouse.

(I) If both spouses are state employees covered by MCHCP, each spouse must enroll separately.

(II) State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.

(III) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(IV) If one spouse is a state employee with MCHCP benefits and the other is a public entity employee with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one employer's plan. The spouses cannot have coverage in both places; and

B. Children.

(I) Children may be covered through the end of the month in which they turn twenty-six (26), if they meet one of the following criteria:

(a) Natural child of subscriber or spouse;

(b) Legally adopted child of subscriber or spouse;

(c) Child legally placed for adoption of subscriber or spouse;

(d) Stepchild of subscriber or spouse;

(e) Foster child of subscriber or spouse;

(f) Grandchild for whom the covered subscriber or covered spouse has legal guardianship or legal custody;

(g) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years of age if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years of age;

(h) Newborn of a subscriber or a covered dependent;

(i) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(j) Child who is twenty-six (26) or older and is permanently disabled in accordance with subsection (5)(C), only if such child was an MCHCP member the day before the child turned twenty-six (26).

(II) A child may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(III) A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time.

(C) Changes in Dependent Status. If a covered dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days to terminate his/her coverage effective the end of the month eligibility ceases.

(D) Retiree, Survivor, Vested, Terminated Vested, and Long-Term Disability Employee; Elected State Officials and their Employee; and Dependent Eligibility Requirements.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is eligible to receive a monthly retirement benefit from either MOSERS or from PSRS for state employment.

A. To enroll or continue coverage at retirement, the employee and his/her dependents must provide all of the following:

(I) Submit a completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date;

(II) Submit a completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two payrolls and the option to pre-pay premiums through the cafeteria plan;

(III) Submit proof of prior coverage and proof of eligibility for dependents if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had other insurance coverage for six (6) months immediately prior to his/her retirement; and

(IV) Submit a statement from PSRS that indicates the effective date of the subscriber's retirement if the subscriber is a PSRS retiree.

B. Employees may continue coverage on their eligible dependents into retirement.

C. If the employee's spouse is a state employee (active or

retired), s/he may transfer coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her own coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

2. An enrolled terminated vested or long-term disability employee and his/her dependents will have continuous coverage into retirement unless the member submits a termination form.

3. A survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits and his/her dependents from MOSERS or PSRS may continue coverage if the survivor had—

A. Coverage through MCHCP at the time of the subscriber's death; or

B. Other health insurance for the six (6) months immediately prior to employee's death. Proof of eligibility for each dependent, proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage), and a list of dependents covered is required.

4. A survivor of a retired employee or long-term disability recipient may continue coverage if the survivor was covered at the time of the employee's death.

5. An employee may participate in an MCHCP plan when his/her employment with the state terminates if s/he is a vested member and is eligible for a future benefit from the MOSERS or PSRS as a state employee when s/he reaches retirement age. The employee must elect to continue coverage within thirty-one (31) days from the last day of the month in which his/her employment is terminated.

A. If a vested employee's spouse is a state employee (active or retired), the vested employee may transfer coverage under the plan in which his/her spouse is enrolled.

B. The employee and his/her dependents must meet one (1) of the following requirements to participate in an MCHCP plan as a terminated vested employee:

(I) Coverage through MCHCP since the effective date of the last open enrollment period; or

(II) Proof of prior group coverage for the six (6) months immediately prior to the termination of state employment. Proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and list of dependents covered is required).

6. If a vested employee does not elect coverage, or if s/he cancels his/her coverage or dependent coverage, the vested employee and his/her dependents cannot enroll at a later date. The vested employee may continue coverage under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA).

7. If any retired, survivor, terminated vested, or long-term disability employee, or his/her dependents who are 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 except as noted in paragraph (2)(D)8.

8. A long-term disability employee must be eligible for long-term disability benefits from MOSERS or PSRS and have had coverage since the effective date of the last open enrollment period.

A. The employee may continue coverage on his/her dependents or add new dependents due to a life event.

B. If the employee becomes ineligible for disability benefits, the employee and his/her dependents may continue coverage as applicable, as a terminated vested, retired, or COBRA subscriber, unless the employee returns to active state employment.

C. If coverage was not elected through MCHCP before the date of disability, the employee and his/her dependents may enroll as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's disability. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and a list of dependents covered is required.

D. If coverage was not maintained while on disability, the employee and his/her dependents may enroll on the date the employee is eligible for retirement benefits as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's retirement. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and a list of dependents covered is required.

E. If the employee's spouse is a state employee (active or retired), s/he may transfer coverage under the plan in which his/her spouse is enrolled.

F. If the employee wishes to be covered individually at a later date, s/he can make the change, as long as coverage is continuous.

G. If the employee returns to work, the employee and his/her state employee spouse must be covered individually.

9. A retiree, survivor, vested employee, or long-term disability employee and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

10. An elected state official or his/her employees may continue coverage in an MCHCP plan if s/he is a member of the General Assembly, a state official holding a statewide office, or employed by a member of the General Assembly or a state official and his/her employment terminates because the state official or member of the General Assembly ceases to hold elected office. The elected state official or his/her employees must elect to continue coverage within thirty-one (31) days from the last day of the month in which his/her employment is terminated. The member will not later be eligible if s/he discontinues coverage at some future time.

(E) Retiree Returns to State Employment. A retiree who returns to state employment will become eligible for benefits through MCHCP and will be treated as a new employee. The employee is eligible to enroll in medical, dental, or vision coverage with any coverage level within the first thirty-one (31) days of his/her hire date.

(3) Enrollment Procedures.

(A) Statewide Employee Benefit Employee System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov within thirty-one (31) days of his/her hire date. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

(B) Open Enrollment.

1. An employee may elect coverage and/or change coverage levels during the annual open enrollment period if one (1) of the following occurred:

A. Waived his/her right to insurance when first eligible;

B. Did not enroll eligible dependents when first eligible; or

C. Dropped his/her or dependent coverage during the year.

2. A retiree, terminated vested, long-term disability, or survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree, terminated vested, long-term disability, or survivor subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in a plan during open enrollment.

(C) Special Enrollment Periods.

1. An employee may apply for coverage for himself/herself or for his/her dependents if one (1) of the following occurs:

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

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. A retiree, terminated vested, long-term disability, or survivor may apply for dependent coverage if one (1) of the following occurs:

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

B. Employer-sponsored group coverage loss. A retiree, terminated vested, long-term disability, or survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. MO HealthNet or Medicaid status loss. If an employee who is not retired, terminated, vested, long-term disability, survivor, or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss.

4. Qualified Medical Child Support Order. If a subscriber receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

5. A survivor must submit a survivor enrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child or adopts a child, the dependent must be added within thirty-one (31) days of birth, adoption, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

6. If an active employee has elected coverage as a dependent of another MCHCP subscriber as allowed by these rules, and the subscriber dies before coverage as a dependent goes into effect, the active employee may elect coverage as a subscriber within thirty-one (31) days of the date of death.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her dependent's coverage begins on the first day of the month after enrollment through SEBES.

2. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. The effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP, except for newborns.

3. The effective date of coverage for a life event shall be as follows:

A. If enrollment by an employee is made before a wedding date, spouse's coverage becomes effective on the wedding date. The monthly premium is not prorated;

B. If enrollment by an employee is made within thirty-one (31) days of a wedding date, spouse's coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

C. If enrollment by a subscriber is made for a newborn of a member, the effective date for the newborn is the birth date. If enrollment is made by an employee due to the birth of a newborn of the employee, the effective date for the employee and newborn is the first of the month coinciding with or after enrollment is received;

D. If enrollment by an employee is made within thirty-one (31) days after the eligibility date, for an adoption, or placement of adopted children, coverage becomes effective on the eligibility date or the first day of the calendar month coinciding with or after the date the enrollment is received; or

E. If enrollment by an employee is made due to legal guardianship of a dependent within thirty-one (31) days of guardianship effective date, the effective date for the dependent is the first day of the calendar month coinciding with or after the date the enrollment is received.

4. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

5. An employee who transferred from a state department with coverage under another medical care plan into a state department covered by this plan, and his/her eligible dependent(s) who were covered by the other medical plan, will have coverage effective immediately if an enrollment form is submitted within thirty-one (31) days of transfer.

6. An employee who terminates all employment with the state (not simply moves from one (1) agency to another) and is rehired as a new state employee before termination of coverage, and his/her eligible dependent(s) who were covered by the plan, will have coverage effective immediately.

A. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

B. If the employee requests coverage within the first thirty-one (31) days of hire date to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee cancels coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January.

7. An employee and his/her eligible dependent(s) who transfers from another state agency with MCHCP benefits to an MCHCP state agency will be transferred by the former state agency's human resource or payroll representative through eMCHCP to the new state agency. The employee must inform the former agency of the transfer in lieu of a termination. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

8. A Qualified Medical Child Support Order is effective the first of the month coinciding with or after the form is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents. Enrollment of a dependent is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, a letter will be sent requesting it. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or eligible dependent(s) will not be added. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will terminate or never take effect. If enrolling dependents during open enrollment, proof of eligibility must be received by November 20, or eligible dependents will not be added for coverage effective the following January 1.

(A) Addition of Dependents. Required documentation should accompany the enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the enrollment will result in the dependent not having coverage until such proof is received, subject to the following:

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one

(31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility. 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; and

2. Coverage is provided for a newborn of a member from the moment of birth. The member must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. The plan will notify the member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the date of birth. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date;

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

Circumstance	**Documentation**
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption; and Lists subscriber as adoptive parent
Legal guardianship of dependent(s)	Court-documented guardianship papers listing member as guardian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified medical child support order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, reason for coverage termination, and list of dependents covered

(B) The employee is required to notify MCHCP on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number.

(C) Permanently disabled children will continue to be eligible beyond age twenty-six (26) during the continuance of a permanent disability, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday:

1. The Supplemental Security Income (SSI) Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

2. A letter from the dependent's physician describing the disability and verifying that the disability predates the SSA determination; and

3. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

(D) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire. The member must submit the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical plan.

(6) Military Leave.

(A) Military Leave for an Employee who is not Retired.

1. For absences of thirty (30) days or less, coverage continues as if the employee has not been absent.

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for COBRA coverage. The agency payroll representative must notify MCHCP of the effective date of military leave.

3. If the employee is utilizing annual and/or compensatory balances and receiving a payroll, the dependent coverage is at the active employee monthly premium.

4. If the employee does not elect to continue COBRA coverage for his/her eligible dependent(s), coverage ends effective the last day of the month in which the leave begins.

5. The former employee must submit a form within thirty-one (31) days of the employee's return to work for the same level of coverage with the same plan to be reinstated. The former employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work.

6. Coverage may be reinstated the first of the month in which the member returns to employment, the first of the month after return to employment, or the first of the month after the loss of military coverage.

(B) Military Leave for a Retired Member.

1. A retiree must terminate his/her coverage upon entry into the armed forces of any country by submitting a form and copy of his/her activation papers within thirty-one (31) days of his/her activation date.

2. Coverage will be terminated the last day of the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of his/her separation papers and form within thirty-one (31) days of the separation date.

3. Coverage will be reinstated as of the first of the month in which the employee returns from active duty, the first of the month after the employee returns, or the first of the month after the loss of military coverage.

4. If the retired member fails to reinstate coverage, s/he cannot enroll at a later date.

5. If the employee terminates his/her coverage, dependent coverage is also terminated.

(7) Termination.

(A) Termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make any required contribution toward the cost of coverage. If MCHCP has not received payment of premium at the end of the thirty-one (31)-day grace period, the subscriber will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period;

2. Entry into the armed forces of any country as defined in section (6);

3. With respect to employees, termination of coverage shall occur upon termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule. Termination of employee's coverage shall terminate the coverage of dependents, except as specified in subsection (2)(D);

4. With respect to dependents, termination of coverage shall occur upon divorce or legal separation from the subscriber; or when a child reaches age twenty-six (26). A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. Subscriber shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter. A subscriber cannot cancel coverage on his/her spouse or children during divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce.

B. When a subscriber drops dependent coverage after a divorce, he/she must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or, if requested, the last day of the month in which the divorce was final;

5. Death of dependent. The dependent's coverage ends on the date of death. The subscriber must submit completed form and a copy of the death certificate within thirty-one (31) days of death;

6. Termination due to a member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

7. Termination due to a member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP;

8. A rescission due only to non-payment of a premium, fraud, or intentional misrepresentation. MCHCP shall provide at least thirty (30) days written notice before it rescinds coverage;

9. Termination of coverage shall occur immediately upon discontinuance of the plan, subject to the plan termination provision specified in 22 CSR 10-2.080(1); and

10. If a member receives covered services after the termination of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP, unless the subscriber notifies MCHCP on the first calendar day of the month; then cancellation of coverage is effective the last day of the previous month.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(B) A subscriber may retroactively cancel coverage on his/her spouse to be effective on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request.

(C) If a member receives covered services after the voluntary cancellation of coverage, MCHCP may recover the contracted charges

for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(D) A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents for one (1) of the following reasons:

1. Upon retirement; or
2. When beginning a leave of absence.

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an 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 MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, form, and bill from MCHCP to continue coverage. If the completed form and payment are returned within ten (10) days of receipt, coverage will continue and the employee will be set up on direct bill.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her covered dependents is suspended effective the last day of the month in which the employee is employed.

3. If the employee fails to pay the premium due, coverage on the employee and his/her dependents terminates.

4. If the employee's spouse is a state employee (active or retired), the employee may transfer coverage under the plan in which the spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

5. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage in MCHCP 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. For coverage to be reinstated, the employee must submit a completed form within thirty-one (31) days. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and requests reinstatement of coverage.

6. If the employee chooses to maintain employee coverage but not coverage for his/her covered dependents, the employee is eligible to regain dependent coverage upon return to work.

(B) Leave of Absence—Family and Medical Leave Act (FMLA).

1. An employee must be approved for a leave of absence under the FMLA and meet the requirements and guidelines set forth by FMLA and his/her employing agency for his/her employer to continue to pay the monthly contribution toward the employee's and his/her dependents' coverage. Coverage is continuous unless the employee chooses to cancel coverage.

2. If the employee cancels coverage, coverage ends on the last day of the month.

3. If the employee cancels coverage, the employee must submit a completed form within thirty-one (31) days of his/her return to work.

4. If the employee is unable to return to work after his/her FMLA leave ends, s/he may elect leave of absence coverage or suspend his/her coverage. If coverage is suspended at that time, s/he can enroll within thirty-one (31) days of his/her return to work.

(C) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. The employee will receive a letter, enrollment form, and bill (if applicable) from MCHCP. If the employee chooses to continue coverage, s/he must return the enrollment form to MCHCP within ten (10) days. If the employee fails to pay the premium due, coverage on the employee and his/her dependents terminates. If the employee's spouse is a state employee (active or retired), the employee may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. If the employee returns to work with an agency covered by MCHCP, the employee and his/her spouse must be covered individually. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If coverage terminates and the employee is recalled to service, eligibility will be as a new employee.

(D) Workers' Compensation.

1. Coverage will automatically be extended to any subscriber who is receiving workers' compensation benefits. Coverage in the plan will be at the same level of coverage (employee only or employee and dependents) and the member must continue to pay the premiums that were previously deducted from his/her paycheck.

2. If the subscriber cancels coverage, coverage will end on the last day of the month in which MCHCP received the cancellation. The employee may enroll in his/her coverage within thirty-one (31) days of returning to work.

3. If the subscriber is no longer eligible for workers' compensation benefits but cannot return to work, the subscriber's status changes to leave of absence.

(E) Reinstatement after Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action, s/he will be allowed to reinstate his/her medical benefit as described below—

1. If the employee is reinstated with back pay, s/he will be responsible for paying any back contributions normally made for his/her coverage;

2. 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 the required contribution for his/her coverage;

3. If the employee does not continue coverage, s/he will be considered a new hire and may enroll in the plan of his/her choice; or

4. If the employee fails to reinstate his/her coverage, s/he cannot enroll in an MCHCP plan until the next open enrollment.

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

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (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 dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, eligible dependents can be added to the subscriber's plan upon notification to MCHCP. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible to Medicare.

4. 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.

5. A divorced spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. 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.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

9. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

(B) Premium Payments.

1. Initial payment for continuation coverage must be received within forty-five (45) days of election of coverage.

2. After initial premium payment, MCHCP bills on the last working day of the month. There is a thirty-one (31) day grace period for payment of regularly scheduled monthly premiums.

3. Premiums for continued coverage will be one hundred two percent (102%) of the total premium for the applicable coverage level. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

(C) Required Notifications.

1. The subscriber or applicable member must notify MCHCP of a divorce, legal separation, a child turning age twenty-six (26), or Medicare entitlement within sixty (60) days of the event date.

2. The human resource/payroll office of the subscriber must notify MCHCP of an employee's death, termination, or reduction of hours of employment.

(D) Election Periods.

1. When MCHCP is notified that a COBRA-qualifying event has occurred, MCHCP notifies eligible members of the right to choose continuation coverage.

2. Eligible members have sixty (60) days from the date of coverage loss or notification from MCHCP, whichever is later, to inform MCHCP that they want continuation coverage.

3. If eligible members do not choose continuation coverage within sixty (60) days of lost coverage or notification from MCHCP, coverage ends.

(E) Continuation of coverage may be cut short for any of these reasons—

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

4. The covered employee or dependent becomes entitled to Medicare after the date s/he elects COBRA coverage; or

5. The covered employee or dependent extends coverage for up to twenty-nine (29) months due to disability and there has been a final determination that the individual is no longer disabled.

(11) Missouri State Law COBRA Wrap-Around Provisions.

(A) Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) under two (2) conditions—

1. The member continues and maintains coverage under the thirty-six (36)-month provision of COBRA; and

2. The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay the entire premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium.

(B) If continuation coverage is not chosen within the proper time frames listed below, continuation of coverage ends—

1. Within sixty (60) days of legal separation or the entry of a decree of dissolution of marriage or prior to the expiration of a thirty-six (36)-month COBRA period, the legally separated or divorced spouse who seeks such coverage shall give MCHCP written notice of the qualifying event, including his/her mailing address;

2. Within thirty (30) days of the death of an employee whose surviving spouse is eligible for continued coverage or prior to the expiration of a thirty-six (36) month COBRA period, the human resource/payroll representative shall give MCHCP written notice of the death and the mailing address of the surviving spouse; or

3. Within fourteen (14) days of receipt of the notice, MCHCP shall notify the legally separated, divorced, or surviving spouse that coverage may be continued. The notice shall include:

A. A form for election to continue the coverage;

B. The amount of premiums to be charged and the method and place of payment; and

C. Instructions for returning the elections form by mail within sixty (60) days after MCHCP mails the notice.

(C) Continuation of coverage terminates on the last day of the month prior to the month the subscriber turns age sixty-five (65). The right to continuation coverage shall also terminate upon the earliest of any of the following:

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The date on which the legally separated, divorced, or surviving spouse becomes insured under any other group health plan;

4. The date on which the legally separated, divorced, or surviving spouse remarries and becomes insured under another group health plan; or

5. The date on which the legally separated, divorced, or surviving spouse reaches age sixty-five (65).

(12) Medicare.

(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.

(C) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.

(13) Communications to Members.

(A) It is the member's responsibility to ensure that MCHCP has current contact information for the member and any dependent(s).

(B) A member must notify MCHCP of a change in his/her mailing or email address as soon as possible, but no later than thirty-one (31) days after the change.

(C) It is the responsibility of all members who elect to receive plan communication through email to ensure plan emails are not blocked as spam or junk mail by the member or by the member's service provider.

(D) Failure to update a mailing or email address may result in

undeliverable mail/email of important informational material, delayed or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

(14) Deadlines. Unless specifically stated otherwise, MCHCP computes deadlines by counting day one as the first day after the qualifying event. If the last day falls on a weekend or state holiday, MCHCP may receive required information on the first working day after the weekend or state holiday.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded and readopted: Filed Nov. 1, 2011.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions $391,364,292 in the aggregate.

PRIVATE COST: This proposed rule will cost private entities $117,801,060 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title:
Division Title:
Chapter Title:

Rule Number and Name:	**22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$391,364,292**

III. WORKSHEET

Estimated cost is the annual MCHCP contribution toward premiums for providing health care plans to enrolled state employees, retirees and dependents for calendar year 2012.

IV. ASSUMPTIONS

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care.
- Actual claim costs will vary based upon actual utilization of services.

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
97,994 individuals enrolled in MCHCP plans for CY 2012	**Individuals enrolled in MCHCP plans for CY 2012**	**$117,801,060**

III. WORKSHEET

Estimated cost is the annual cost for all MCHCP subscribers' premiums for calendar year 2012.

IV. ASSUMPTIONS

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

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

PROPOSED AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending sections (1) and (2); adding sections (3)–(5); and renumbering as necessary.

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

(1) Total premium costs for various *[classes]* **levels** of employee *[participation]* **coverage are** based on employment status, eligibility for Medicare**,** and *[for]* various classifications of dependent participation *[are]* **as** established by the plan administrator.

(2) The **employee's** contribution *[by the employee]* **toward total premium** shall be determined by the plan administrator *[for state employees]*.

(3) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium is based on creditable years of service at retirement with the state. It is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%). After the percentage is computed, the percentage is multiplied by the PPO 600 Plan total premium for non-Medicare retirees, the percentage is multiplied by the PPO 600 Plan total premium reduced by both the tobacco-free incentive and the wellness incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

(4) Premium. Payroll deductions, Automated Clearing House (ACH) transactions, and/or direct bills are processed by MCHCP.

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

A. If past premiums are owed due to timing of the receipt of the form, timing of the receipt of proof of eligibility or other circumstances, premium payroll deductions due are divided and taken in up to three (3) of the employees' future payrolls and/or additional payrolls at the discretion of MCHCP.

(B) Active Employee Whose Payroll Information is not Housed in the SAM II Human Resource System.

1. Premium payroll deductions are submitted to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If premiums are owed due to timing of the receipt of the change, the agency collects the premiums owed and includes the premium with the monthly deductions submitted the next month.

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deductions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit check deduction is taken for October medical, dental, and vision premiums).

(D) Direct Bill for Consolidated Omnibus Budget Reconciliation Act (COBRA), Long-Term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

2. If a member is in arrears for two (2) months of premiums and payment is not received by the fifteenth of the second month for which premiums are due, coverage is terminated due to nonpayment on the last day of the month for which full premium was received. The member will be responsible for the value of the services rendered after the retroactive termination date (example: bill sent September 30 for October premiums and no payment received; bill mailed October 31 for October and November premiums due on November 15. If payment is not received, coverage will be terminated due to nonpayment effective September 30).

(E) ACH Electronic Payment of Premiums for COBRA, Long-Term Disability, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental, and vision premiums).

2. If there are insufficient funds, MCHCP will send the member a letter and bill requesting payment. If a payment is in arrears, the direct bill timeline applies as defined in paragraph (4)(D)2.

(5) Premium Payments.

(A) By enrolling in coverage under MCHCP, a member agrees that MCHCP may deduct the member's contribution toward the total premium from the member's paycheck. Payment for the first month's premium is made by payroll deduction. Double deductions may be taken to pay for the first month's coverage depending upon the date the enrollment is received and the effective date of coverage. Subsequent premium payments are deducted from the member's payroll.

(B) A retiree or survivor has a choice to have the premium deducted from his/her retirement check or survivor's benefit check, automatically withdrawn from the retiree's or survivor's bank account, or may receive a monthly bill from MCHCP.

1. If the retirement check or survivor's benefit check is not sufficient to cover the premium, the retiree's or survivor's contribution toward total premium, the contribution may be either automatically withdrawn from the retiree's or survivor's bank account, or the retiree or survivor may elect to receive a monthly bill.

2. If the retiree or survivor fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received.

3. If coverage terminates on the retiree, survivor, vested, or COBRA subscriber or his/her dependents, the subscriber cannot enroll in the plan at a later date. The subscriber is responsible for claims submitted after the termination date.

(C) If a member fails to pay premiums on the required due date, MCHCP allows a thirty-one (31)-day grace period. In the event that MCHCP has not received payment of premium at the end of the thirty-one (31)-day grace period, the member will be retroactively terminated to the date covered by the member's last paid premium. The member will be responsible for the value of the services rendered after the retroactive termination date, including, but not limited to, the grace period.

*[(3)]***(6)** Refunds of overpayments are limited to the amount overpaid during the twelve (12)-month period ending at the end of the month preceding the month during which notice of overpayment is received.

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 Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions $391,364,292 in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities $117,801,060 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title:
Division Title:
Chapter Title:

Rule Number and Name:	**22 CSR 10-2.030 Contributions**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	**$391,364,292**

III. WORKSHEET

Estimated cost is the annual cost of the MCHCP providing health care plans to all state employees and eligible retirees and dependents for calendar year 2012.

IV. ASSUMPTIONS

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care.
- Actual costs will vary based upon actual utilization of services.

FISCAL NOTE
PRIVATE COST

I. Department Title: 22 - Missouri Consolidated Health Care Plan
Division Title: Division 10
Chapter Title: Chapter 2

Rule Number and Title:	**22 CSR 10-2.030 Contributions**
Type of Rulemaking:	**Proposed Amendment**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
97,994 individuals enrolled in MCHCP plans for CY 2012	**Individuals enrolled in MCHCP plans for CY 2012**	**$117,801,060**

III. WORKSHEET

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for calendar year 2012.

IV. ASSUMPTIONS

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.