This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety (90)-day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 10—Director, Department of Mental Health
Chapter 5—General Program Procedures

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Mental Health under section 630.050, RSMo Supp. 2011, the department adopts a rule as follows:

9 CSR 10-5.240 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on November 15, 2011 (36 MoReg 2369–2373). Those sections with changes are reprinted here. This proposed rule becomes effective **June 29, 2012**.

SUMMARY OF COMMENTS: The department received comments from (4) individuals on the proposed rule.

COMMENT #1: Teresa Condor and Allyson Ashley of Burrell Behavioral Health commented that in subsection (1)(D) using the words "primary care provider" implies that primary care treatments and management will be conducted at the facility when it will actually be the coordination and management of access to care.

Ms. Condor also commented that in subsection (3)(C), it states "coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines" is unclear. She commented this implies that primary care treatments and management will be conducted at the facility when it will actually be the coordination and management of access to care as noted above. She commented that in subsection (4)(D) the same concern exists.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees with the comment regarding subsection (1)(D) and has revised the rule as requested. The department disagrees that the language in subsection (3)(C) or subsection (4)(D) is unclear. The department notes the previous revision to the rule in subsection (1)(D) should provide clarification.

COMMENT #2: Ms. Condor and Ms. Ashley of Burrell Behavioral Health commented that in paragraph (2)(B)1. three (3) months is an unrealistic expectation to have a contract or Memorandum of Understanding (MOU) developed with regional hospitals.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees with the comment regarding contracts or MOUs recognizing that while a contract or MOU may not be final in three (3) months, it would be under development and revised the rule as requested.

COMMENT #3: Ms. Condor also commented that the phrase in paragraph (2)(B)1. "maintain a mutual awareness and collaboration to identify individuals seeking emergency department services that might benefit from connection with a Home Health site" may pose difficulties because when they reach maximum allocations, they will not be able to enroll more patients. She commented that in subsection (4)(D) the same concern exists.
RESPONSE: The department disagrees that the language would require enrolling more patients than their maximum allocations would allow, and no changes have been made as a result.

COMMENT #4: Ms. Ashley of Burrell Behavioral Health commented that in paragraph (2)(A)2. a requirement to present the approved PowerPoint introduction "Paving the Way for Health Homes" to all staff is not necessary.
RESPONSE: The department recognizes that all staff may be involved with the provision of services to patients, and no changes have been made as a result of the comment.

COMMENT #5: Markus Cicka commented that the use of words such as substantial, routinely, demonstrate, and determined by the Department of Mental Health (DMH), without more specific requirements will make it difficult to conduct an audit, unless those standards are incorporated in their provider manual and incorporated by reference in a rule. Ms. Ashley of Burrell Behavioral Health also commented that in paragraph (2)(A)3. minimum access requirements are not defined.
RESPONSE: The department disagrees that the language is unclear or definitions unavailable and made no changes as a result of the comments.

COMMENT #6: Department staff commented that in section (1) language should be added to define the Missouri Medicaid Audit and Compliance unit (MMAC) and in section (3) language should be added to provide that Community Mental Health Centers (CMHCs) shall work cooperatively with the department to support approved training, technology, and administrative services required for the implementation of the Health Care Home program.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees with these comments and has revised the rule as requested.

9 CSR 10-5.240 Health Home

(1) Definitions.

(D) Health Home (also referred to as Health Care Home)—A site that provides comprehensive behavioral health care coordinated with comprehensive primary physical care to Medicaid patients with behavioral health and/or chronic physical health conditions, using a partnership or team approach between the Health Home practice's/site's health care staff and patients in order to achieve improved primary

care and to avoid hospitalization or emergency room use.

(F) Missouri Medicaid Audit and Compliance Unit (MMAC)—The unit within the Department of Social Services (DSS) which directly manages and administers Medicaid provider review, program integrity, audit and compliance initiatives, and provider contracts of the Medicaid program.

(G) MO HealthNet Division (MHD)—The Missouri Medicaid agency.

(H) Needy individuals—Individuals receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP), or are furnished uncompensated care by the provider, or furnished services at either no cost or reduced cost based on a sliding scale.

(2) Health Home Qualifications.

(B) Ongoing Provider Qualifications. Each CMHC must also—

1. Within three (3) months of Health Home service implementation, have a contract or Memorandum of Understanding (MOU) under development with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking emergency department (ED) services that might benefit from connection with a Health Home site, and in addition motivate hospital staff to notify the CMHC primary care nurse manager or staff of such opportunities;

2. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;

3. Demonstrate continuing development of fundamental Health Home functionality at six (6) months and twelve (12) months through an assessment process to be determined by DMH;

4. Demonstrate improvement on clinical indicators specified by and reported to the state; and

5. Meet accreditation standards approved by the state as such standards are developed.

(3) Scope of Services. This section describes the activities CMHCs will be required to engage in and the responsibilities they will fulfill if recognized as a Health Home provider.

(I) CMHCs shall work cooperatively with DMH to support DMH approved training, technology, and administrative services required for implementation of the Health Care Home Program.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-5.040 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2232–2233). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received fifteen (15) comments from three (3) sources: U.S. Environmental Protection Agency (EPA) Region 7, Hunt Industrial Service Corporation, and St. Louis County Department of Health.

COMMENT #1: EPA recommended removing the reference to New York style pizza from the exemption for pizza and bakery ovens in subsection (1)(D).
RESPONSE AND EXPLANATION OF CHANGE: Referring to New York style pizza may lead to confusion since there is no consensus on the characteristic that distinguishes New York style pizza from other pizza. Removing the reference to New York style will avoid this confusion without changing the meaning of the exemption. Therefore, the reference to New York style was removed from the exemption for pizza and bakery ovens.

COMMENT #2: EPA commented that record-keeping requirements should be added to section (4) and the records should be retained for at least five (5) years.
RESPONSE AND EXPLANATION OF CHANGE: Suitable record-keeping requirements are a valuable tool for determining compliance. As a result, provisions have been added to section (4) to require sources to keep records to demonstrate compliance, and to maintain the records for at least five (5) years.

COMMENT #3: Hunt Industrial Service Corporation provided a comment letter to support the proposed amendment. They are a small, family-owned business with three (3) hand-fired devices that can be fueled with scrap wood generated by their business activity. Burning this scrap on a limited basis during the cold season would divert solid waste from landfills and utilize low-cost, renewable fuels as an alternative to fossil fuels. The energy harvested from their wood scrap will provide building heat during the winter months.
RESPONSE: The Air Program thanks Hunt Industrial Service Corporation for their support of the proposed amendment. No changes have been made to the rule text as a result of this comment.

COMMENT #4: St. Louis County Health Department does not support the rule amendment as proposed based on several concerns. They do not believe that allowing the burning of biomass or woody waste in places of business for building or process heat is an environmentally sound waste disposal practice or waste disposal option in the St. Louis area. They are concerned that fueling hand-fired equipment with biomass, even if only during the winter months, will result in emissions of particulate matter and black carbon that exacerbate ambient particulate levels and contribute to climate change. Examples were provided of two (2) homemade wood-burning stoves that required enforcement action for stacks emitting black smoke and ash. In both cases, the business claimed to be burning clean wood.
RESPONSE: This project was initiated in late 2009 when a small business in the St. Louis area requested a variance from 10 CSR 10-5.040 to allow them to burn their wood waste for building heat. Their request also asked that the rule be changed to permanently allow this practice. The Missouri Air Conservation Commission approved this request and a rulemaking was started to investigate the use of hand-fired equipment in the St. Louis area. In June 2011, the draft rule text and Regulatory Impact Report were made publicly available for a sixty (60)-day comment period as required by statute. No comments were received during the sixty (60)-day comment period and the proposed amendment was presented for public hearing at the December 8, 2011 meeting of the Missouri Air Conservation Commission. The basic premise of the proposed amendment is to allow the use of suitable fuels in hand-fired equipment at small sources that are below permitting thresholds. Larger sources would still be required to follow the permitting process. The Air Program shares St. Louis County's concerns about particulate matter and all other air emissions in the St. Louis area. To ensure this rulemaking has no impact on St. Louis air quality, the Air Program estimated emissions from small sources using hand-fired equipment fueled with clean, dry wood. These emissions were compared to baseline emissions and the incremental emissions from hand-fired equipment were found to be insignificant. The Air

Program recognizes St. Louis County's concerns regarding climate change impacts from wood burning due to emissions of black carbon. The effect on climate change from combustion of clean wood in the small volumes proposed in the rule amendment would be negligible compared to total emissions in the St. Louis area. At present, Missouri only regulates greenhouse gas emissions as mandated by EPA. The greenhouse gas permitting requirements do not apply to the small sources covered by this rule, nor do they apply to black carbon emissions. In any case, sources affected by this rulemaking must still comply with all applicable state opacity and odor regulations, and any source that becomes a public or private nuisance would be handled on a case-by-case basis. Therefore, no changes have been made to the rule text as a result of this comment.

COMMENT #5: St. Louis County Health Department noted that biomass is not defined in the rule or in 10 CSR 10-6.020 Definitions and Common Reference Tables. They recommended adding a clear definition for biomass or removing it from rule and only allow burning of clean wood.
RESPONSE AND EXPLANATION OF CHANGE: All known sources affected by this rulemaking desire to burn clean wood. Removal of the provision for burning clean biomass would not change the nature of the rulemaking and would minimize confusion regarding allowable fuels. Therefore, all references to clean biomass have been removed from the rule and the list of prohibited fuels has been deleted since it is no longer necessary. The only permissible fuel will be clean, dry wood.

COMMENT #6: St. Louis County Health Department commented that the requirement to follow best combustion practices is too vague and will result in confusion for regulating agencies. Instead, they recommended requiring the units be operated and maintained in accordance with manufacturer's specifications.
RESPONSE AND EXPLANATION OF CHANGE: The requirement to follow best combustion practice is intended to ensure that devices are operated to maximize efficiency and minimize emissions. The terminology of best combustion practice is often associated with Best Available Control Technology (BACT) for larger permitted sources and applying it to small devices regulated in this rule may lead to confusion. Therefore, the requirement has been changed to require hand-fired equipment be operated to minimize emissions at all times, including following all manufacturer's operation and maintenance guidelines. This change makes the requirements for leak-free doors and proper damper operation redundant, and they have been removed. With these deletions, a definition of start-up is no longer required, and it has also been removed from the rule.

COMMENT #7: St. Louis County Health Department recommended that non-manufactured units be prohibited in the rule.
RESPONSE AND EXPLANATION OF CHANGE: The quality of design, testing, and fabrication of homemade equipment would not typically be as high as commercially-manufactured equipment. Homemade equipment also lacks manufacturer's operating and maintenance guidelines. Emissions from homemade equipment would be higher than emissions from commercially-manufactured equipment. Therefore, a provision has been added to the rule that only allows use of hand-fired equipment that is commercially manufactured.

COMMENT #8: St. Louis County Health Department noted that there are no record-keeping requirements for the thirty (30) ton limit on combustion fuel. They recommend that facilities maintain a twelve (12)-month rolling period of type, quantity, and moisture content of materials burned for a sixty (60)-month period.
RESPONSE AND EXPLANATION OF CHANGE: As noted in the response to comment #2, provisions have been added to the rule to require sources to keep records necessary to demonstrate compliance and to maintain the records for at least five (5) years. The per-year limit achieves the same result as the suggested twelve (12)-month rolling period, but requires less burdensome recordkeeping for the small businesses regulated by this rule. To avoid confusion, the thirty (30) ton per year limit has been changed to thirty (30) tons per calendar year.

COMMENT #9: St. Louis County Health Department requested clarification for the basis of the twenty-five percent (25%) moisture content limit for combustion fuel. They asked if the twenty-five percent (25%) is the ideal moisture content for producing minimal emissions.

RESPONSE: The twenty-five percent (25%) maximum moisture content is intended to ensure that only seasoned, dry wood is used as fuel, with the goal of minimizing incomplete combustion and emissions. There is no universally-accepted moisture content that separates dry wood from wet wood, but twenty percent (20%) is the value used in EPA's emission factors documentation. Allowing moisture content up to twenty-five percent (25%) will allow for a reasonable margin of error without significant increases in emissions. Therefore, no changes have been made to the rule text as a result of this comment.

COMMENT #10: St. Louis County Health Department recommended that regulated facilities be required to perform a daily moisture content test on material prior to burning, document the results, and make the records available for review during regulatory inspections.

RESPONSE: Requiring regulated sources, many of which are small businesses, to perform daily moisture content tests is overly burdensome and would not significantly lower emissions from hand-fired devices. Accurately measuring the moisture content of wood in its various forms requires time and equipment that is beyond the capabilities of most sources regulated by this rule. Knowledge of the type and origin of wood waste is sufficient to demonstrate that emissions are being minimized by burning only dry, seasoned fuel. No changes have been made to the rule text as a result of this comment.

COMMENT #11: St. Louis County Health Department noted that some of the language in the proposed amendment appears to be from a model regulation for outdoor hydronic heaters provided by Northeast States for Coordinated Air Use Management (NESCAUM). They request that another part of the same document be added to prohibit any person from operating hand-fired equipment in such a fashion as to create a public or private nuisance.

RESPONSE: The provisions of the proposed amendment for stack height and prohibited fuels are similar to language in the NESCAUM model regulation. As noted in the response to comment #5, the list of prohibited fuels was deleted when biomass fuel was removed from the rule. The proposed requirements, in conjunction with applicable state opacity and odor regulations, are intended to prevent a source from becoming a public or private nuisance. Adding a prohibition on operating hand-fired equipment in such a manner as to create a public or private nuisance is fundamentally redundant. Regulated sources that become a nuisance in spite of compliance with state and local regulations would be handled on a case-by-case basis. No changes have been made to the rule text as a result of this comment.

COMMENT #12: St. Louis County Health Department also noted that the NESCAUM model regulation suggests property line setbacks for outdoor hydronic heaters and requested clarification on whether the rule includes outdoor units and whether the need for property line setbacks had been considered.

RESPONSE: The proposed amendment applies to both indoor and outdoor units and makes no distinction between the two. The property line setbacks suggested by NASCAUM in their model rule range from three hundred (300) feet to five hundred (500) feet and are impractical for sources in urban areas such as St. Louis. As stated in the response to comment #11, regulated sources that become a nuisance would be handled on a case-by-case basis. Therefore, no changes have been made to the rule as a result of this comment.

COMMENT #13: St. Louis County Health Department recommended adding a requirement to post a permanent, conspicuous label summarizing the hand-fired equipment operating procedures, a list of prohibited fuels, a summary of the current visible emission standard, and statements regarding the importance of proper operation and maintenance.
RESPONSE: Labels are not necessary since equipment operation guidelines were added as a result of comment #6. Requiring them would be overly burdensome and impractical for the applicable sources, many of which are small businesses. Therefore, no changes have been made to the rule as a result of this comment.

COMMENT #14: St. Louis County Health Department recommended that hand-fired units only be allowed to operate during non-ozone season, September 16 through April 14, to be consistent with open burning regulations.
RESPONSE: All known sources are small businesses and only plan to operate their hand-fired equipment to provide building heat during the winter months, which is outside any regulatory ozone season. Even if the hand-fired equipment were operated during ozone season, the very small estimated emissions from these devices would have no measureable impact on ground-level ozone levels in the St. Louis area. Therefore, no changes have been made to the rule as a result of this comment.

COMMENT #15: St. Louis County Health Department recommended adding language that only allows burning of clean wood waste generated from a facility's processes. This will prevent a facility from bringing wood from other sources to burn in their device.
RESPONSE AND EXPLANATION OF CHANGE: Adding a restriction that only allows facilities to burn process waste generated onsite is consistent with the intent of the proposed amendment and the appropriate language has been added to the rule.

10 CSR 10-5.040 Control of Emissions From Hand-Fired Equipment

(1) Applicability. This rule shall apply to all hand-fired, fuel-burning equipment at commercial facilities, including, but not limited to furnaces, heating and cooking stoves, and hot water furnaces with the exception of the following:

(D) Ovens that only burn wood, charcoal, or anthracite coal for pizzas or bakery products;

(2) Definitions.

(A) Clean wood—Wood that has not been treated (including, but not limited to, treatment with copper chromium arsenate, creosote, or pentachlorophenol) and has no paint, stain, or any other type of coating.

(B) Definitions of certain terms specified in this rule, other than those defined in this rule section, may be found in 10 CSR 10-6.020.

(3) General Provisions. No owner or operator shall operate applicable hand-fired, fuel-burning equipment unless the following conditions are met:

(A) Hand-fired equipment shall be operated to minimize emissions at all times. This includes, but is not limited to, following all manufacturers' operation and maintenance guidelines;

(B) Hand-fired equipment must be commercially manufactured;

(C) Hand-fired equipment may only burn process waste generated onsite;

(E) Fuel shall be clean wood with a moisture content less than or equal to twenty-five percent (25%); and

(F) Each piece of equipment shall burn no more than thirty (30) tons of fuel per calendar year.

(4) Reporting and Record Keeping.

(A) The owner or operator of hand-fired equipment subject to this rule shall keep records necessary to determine compliance.

(B) Records verifying that only dry wood was used for fuel may be used to demonstrate compliance with the moisture content requirement.

(C) Records required under subsections (4)(A) and (4)(B) of this rule shall be retained by the owner or operator for a minimum of five (5) years. These records shall be made available to the director upon request.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-5.130 Certain Coals to be Washed **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2233). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received no comments on the proposed amendment.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-5.455 Control of Emissions From Industrial Solvent Cleaning Operations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2233–2234). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received three (3) comments from three (3) sources: The American Coatings Association, U.S. Paint Corporation, and Lighthouse for the Blind Industries.

Due to similarities in the comments, one (1) response will be provided for all comments.

COMMENT #1: The American Coatings Association supports the

proposed amendment, as it will allow effective process equipment cleaning at coating, ink, and resin manufacturers. They note that similar language is being adopted by many other states.
COMMENT #2: U.S. Paint Corporation supports the proposed amendment. The revised compliance options will allow them to clean their equipment with solvents that are suitable for their specialty coatings without being hazardous to their employees.
COMMENT #3: Lighthouse for the Blind Industries expressed support of the proposed amendment. While they presently are able to comply with the rule, potential changes to their products may make future compliance extremely difficult without the proposed amendment.
RESPONSE: The Air Program thanks the commenters for their support of the proposed amendment. No changes have been made to the rule text as a result of these comments.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-5.490 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2234–2246). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received ten (10) comments from three (3) sources on this rule amendment: a representative for the Missouri solid waste industry and the Environmental Industry Association, an attorney representing the IESI Corporation, and the U.S. Environmental Protection Agency (EPA).

Due to the similarity in the following two (2) comments, one (1) response that addresses these comments is at the end of these two (2) comments:

COMMENT #1: The representative for the Missouri solid waste industry and the Environmental Industry Association commented that the industry was not aware of this regulation until it was sent out electronically a few days before the *Missouri Register* came out. In the future it is expected that programs within the department would make each other aware of rulemakings in development so that involved companies can work with staff a little earlier.
COMMENT #2: The attorney representing IESI Corporation commented that he echoed the comments made by the representative for the solid waste industry about involving industry early on in rulemakings before seeing rule actions published in the *Missouri Register*. However, the proposed amendments should be adopted to bring Missouri into compliance with the federal laws. They believe they are already in compliance with these proposed changes because they already meet the federal New Source Performance Standards.
RESPONSE: The Air Program regrets these commenters were not aware of this rulemaking earlier. This rulemaking simply updated state rules for consistency with federal requirements. The Air Program communicated the proposed rulemaking with industry in general and other stakeholders via the Air Forum email listserv and within the department through the rulemaking process prior to filing with the secretary of state on September 26, 2011. The proposed rulemaking was made available for public review and comment by publishing in the *Missouri Register* and posting on the Air Program's Rulemakings on Public Notice webpage on November 1, 2011. However, based on these comments the Air Program is evaluating how to better communicate rulemakings with industry and other programs within the department beyond our current activities. No wording changes have been made to the rule text as a result of these comments.

COMMENT #3: EPA commented that the last sentence in subsection (1)(B) references the Clean Air Act. This reference should be to the *Code of Federal Regulations*.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, the last sentence in subsection (1)(B) has been revised to reference the *Code of Federal Regulations*.

COMMENT #4: EPA commented that subsection (3)(C) was added and discusses incorporation by reference. The EPA does not believe that the reference to 52.21 is relevant to this rule because it relates to the Prevention of Significant Deterioration program and is not relevant for municipal solid waste landfills.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subsection (3)(C) rule text has been revised to indicate that certain references to the department should be used in place of the federal counterpart for incorporating federal regulations in the state rule.

COMMENT #5: EPA commented for rule 10 CSR 10-6.310 that the rule incorporates by reference the *Code of Federal Regulations* (CFR) as of June 30th. EPA believes the more appropriate date would be July 1st to specifically reference the *Code of Federal Regulations* compilation date.
RESPONSE AND EXPLANATION OF CHANGE: Since rule 10 CSR 10-5.490 also contains a similar incorporation by reference in subsection (3)(C) of the rule and both rule amendments were presented together, EPA's comment on 10 CSR 10-6.310 is also applicable to 10 CSR 10-5.490. Therefore, the first sentence in subsection (3)(C) has been revised to the July 1st date.

COMMENT #6: EPA commented that the citation in subsection (4)(G) is incorrect. There is no paragraph (3)(A)3. and EPA believes the correct citation is paragraph (6)(A)3.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subsection (4)(G) rule text has been revised with the correct citation to paragraph (6)(A)3.

COMMENT #7: EPA commented that in paragraph (6)(C)1. that words are missing regarding surface monitoring of methane concentrations. The language should include a reference to thirty (30)-meter intervals (or a site-specific established spacing).
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, paragraph (6)(C)1. rule text has been revised to include the suggested wording that will match the federal regulation.

COMMENT #8: EPA commented that subparagraph (8)(B)1.B. appears to have a typographical error. The threshold for nonmethane organic compound (NMOC) emissions is set at twenty-five (25) megagrams per year throughout the rule. However, subparagraph (8)(B)1.B. includes the EPA threshold of fifty (50) megagrams and it should be changed to reflect the NMOC emission rate of twenty-five (25) megagrams per year.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subparagraph (8)(B)1.B. rule text has been changed to the correct value of twenty-five (25).

COMMENT #9: EPA commented that subsection (9)(A) should be

reworded so that the intent related to record-keeping requirements is clear. EPA suggested moving up the third sentence of this paragraph to follow the first sentence of this paragraph in order to identify that the longer period references the on-site requirements rather than the off-site provisions.
RESPONSE AND EXPLANATION OF CHANGE: To make the wording of this subsection clearer, subsection (9)(A) rule text has been revised by moving the proposed third sentence to follow the first sentence.

COMMENT #10: EPA commented that reference is made to subparagraph (9)(B)3.A. in subparagraph (9)(C)1.B. EPA did not find this subparagraph and believes the correct citation may be paragraph (9)(B)3.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subparagraph (9)(C)1.B. rule text has been revised to the correct citation of paragraph (9)(B)3.

10 CSR 10-5.490 Municipal Solid Waste Landfills

(1) Applicability.

(B) For purposes of obtaining an operating permit under Title V of the Clean Air Act, the owner or operator of an MSW landfill subject to this rule with a design capacity less than two and one-half (2.5) million megagrams or two and one-half (2.5) million cubic meters is not subject to the requirements to obtain an operating permit for the landfill under 40 *Code of Federal Regulations* (CFR) 70 or 71, unless the landfill is otherwise subject to either 40 CFR 70 or 71. For purposes of submitting a timely application for an operating permit under 40 CFR 70 or 71, the owner or operator of an MSW landfill subject to the rule with a design capacity greater than or equal to two and one-half (2.5) million megagrams and two and one-half (2.5) million cubic meters on the effective date of EPA approval of the state's program under section 111(d) of the Clean Air Act (June 23, 1998), and not otherwise subject to either 40 CFR 70 or 71, becomes subject to the requirements of 40 CFR 70.5(a)(1)(i) or 71.5(a)(1)(i) ninety (90) days after the effective date of such 111(d) program approval, even if the design capacity report is submitted earlier.

(3) Standards for Air Emissions from Municipal Solid Waste Landfills. Provisions of 40 CFR 51, 40 CFR 52, 40 CFR 60, and 40 CFR 258 are incorporated by reference in subsection (3)(C) of this rule. Also, the *Compilation of Air Pollutant Emission Factors, Volume I: Stationary Point and Area Sources*, AP-42, Fifth Edition, January 1995 (hereafter AP-42), as published by the Government Printing Office, 732 North Capitol Street NW, Washington, DC, 20401, shall apply and is hereby incorporated by reference, including Supplement E dated November 1998. This rule does not incorporate any subsequent amendments or additions.

(C) The specific citations of 40 CFR 51, 40 CFR 52, 40 CFR 60, and 40 CFR 258 referenced in this rule and published July 1, 2011, shall apply and are hereby incorporated by reference in this rule, as published by the Office of the Federal Register, U.S. National Archives and Records, 700 Pennsylvania Avenue NW, Washington, DC 20408. This rule does not incorporate any subsequent amendments or additions. Certain terms used in 40 CFR refer to federal officers and agencies. The following terms applicable to Missouri shall be substituted where appropriate for the delegable federal counterparts: Director shall be substituted for Administrator and Missouri Department of Natural Resources shall be substituted for EPA, EPA Regional Office, or Environmental Protection Agency.

(4) Operational Standards for Collection and Control Systems. Each owner or operator of an MSW landfill gas collection and control system used to comply with the provisions of subparagraph (3)(B)2.B. of this rule shall—

(G) If monitoring demonstrates that the operational requirements in subsection (4)(B), (C), or (D) of this rule are not met, corrective action shall be taken as specified in paragraphs (6)(A)3. through 5. or subsection (6)(C) of this rule. If corrective actions are taken as specified in section (6) of this rule, the monitored exceedance is not a violation of the operational requirements in this section.

(6) Compliance Provisions.

(C) The following procedures shall be used for compliance with the surface methane operational standard as provided in subsection (4)(D) of this rule:

1. After installation of the collection system, the owner or operator shall monitor surface concentrations of methane along the entire perimeter of the collection area and along a pattern that traverses the landfill at thirty (30)-meter intervals (or a site-specific established spacing) for each collection area on a quarterly basis using an organic vapor analyzer, flame ionization detector, or other portable monitor meeting the specification provided in subsection (6)(D) of this rule.

2. The background concentration shall be determined by moving the probe inlet upwind and downwind outside the boundary of the landfill at a distance of at least thirty (30) meters from the perimeter wells.

3. Surface emission monitoring shall be performed in accordance with section 4.3.1 of Method 21 of 40 CFR 60, Appendix A, except that the probe inlet shall be placed within five to ten centimeters (5–10 cm) of the ground. Monitoring shall be performed during typical meteorological conditions.

4. Any reading of five hundred parts per million (500 ppm) or more above background at any location shall be recorded as an exceedance and the actions specified in subparagraphs (6)(C)4.A. through E. of this rule shall be taken. As long as the specified actions are taken, the exceedance is not a violation of the operational requirements of subsection (4)(D) of this rule.

A. The location of each monitored exceedance shall be marked, and the location recorded.

B. Cover maintenance or adjustments to the vacuum of the adjacent wells to increase the gas collection in the vicinity of each exceedance shall be made, and the location shall be remonitored within ten (10) calendar days of detecting the exceedance.

C. If the remonitoring of the location shows a second exceedance, additional corrective action shall be taken, and the location shall be monitored again within ten (10) days of the second exceedance. If the remonitoring shows a third exceedance for the same location, the action specified in subparagraph (6)(C)4.E. of this rule shall be taken, and no further monitoring of that location is required until the action specified in subparagraph (6)(C)4.E. of this rule has been taken.

D. Any location that initially showed an exceedance but has a methane concentration less than five hundred parts per million (500 ppm) methane above background at the ten (10)-day remonitoring specified in subparagraph (6)(C)4.B. or C. of this rule shall be remonitored one (1) month from the initial exceedance. If the one (1)-month remonitoring shows a concentration less than five hundred parts per million (500 ppm) above background, no further monitoring of that location is required until the next quarterly monitoring period. If the one (1)-month remonitoring shows an exceedance, the actions specified in subparagraph (6)(C)4.C. or E. of this rule shall be taken.

E. When any location equals or exceeds five hundred parts per million (500 ppm) methane above background three (3) times within a quarterly period, a new well or other collection device shall be installed within one hundred twenty (120) calendar days of the initial exceedance. An alternative remedy to the exceedance, such as upgrading the blower, header pipes, or control device, and a corresponding time line for installation may be submitted to the director for written approval.

5. The owner or operator shall implement a program to monitor for cover integrity and implement cover repairs as necessary on a monthly basis.

(8) Reporting Requirements. Except as provided in part (3)(B)2.A.(II) of this rule—

(B) Each owner or operator subject to the requirements of this rule shall submit an NMOC emission rate report to the director initially and annually thereafter, except as provided for in subparagraph (8)(B)1.B. or paragraph (8)(B)3. of this rule. The director may request such additional information as may be necessary to verify the reported NMOC emission rate.

1. The NMOC emission rate report shall contain an annual or five (5)-year estimate of the NMOC emission rate calculated using the formula and procedures provided in subsection (5)(A) or (B) of this rule, as applicable.

A. The initial NMOC emission rate report shall be submitted within ninety (90) days of the rule effective date and may be combined with the initial design capacity report required in subsection (8)(A) of this rule. Subsequent NMOC emission rate reports shall be submitted annually thereafter, except as provided for in subparagraph (8)(B)1.B. and paragraph (8)(B)3. of this rule.

B. If the estimated NMOC emission rate as reported in the annual report to the director is less than twenty-five (25) megagrams per year in each of the next five (5) consecutive years, the owner or operator may elect to submit an estimate of the NMOC emission rate for the next five (5)-year period in lieu of the annual report. This estimate shall include the current amount of solid waste-in-place and the estimated waste acceptance rate for each year of the five (5) years for which an NMOC emission rate is estimated. All data and calculations upon which this estimate is based shall be provided to the director. This estimate shall be revised at least once every five (5) years. If the actual waste acceptance rate exceeds the estimated waste acceptance rate in any year reported in the five (5)-year estimate, a revised five (5)-year estimate shall be submitted to the director. The revised estimate shall cover the five (5)-year period beginning with the year in which the actual waste acceptance rate exceeded the estimated waste acceptance rate.

2. The NMOC emission rate report shall include all the data, calculations, sample reports, and measurements used to estimate the annual or five (5)-year emissions.

3. Each owner or operator subject to the requirements of this rule is exempted from the requirements of paragraphs (8)(B)1. and 2. of this rule after the installation of a collection and control system in compliance with paragraph (3)(B)2. of this rule, during such time as the collection and control system is in operation and in compliance with sections (4) and (6) of this rule.

(9) Record-Keeping Requirements. Except as provided in part (3)(B)2.A.(II) of this rule—

(A) Each owner or operator of an MSW landfill subject to the provisions of subsection (3)(B) of this rule shall keep for at least five (5) years up-to-date, readily accessible, on-site records of the design capacity report which triggered subsection (3)(B) of this rule, the current amount of solid waste-in-place, and the year-by-year waste acceptance rate. A longer period is acceptable if records are needed for an unresolved enforcement action. Records may be maintained off-site if they are retrievable within four (4) hours. Either paper copy or electronic formats are acceptable;

(C) Each owner or operator of a controlled landfill subject to the provisions of this rule shall keep for five (5) years up-to-date, readily accessible continuous records of the equipment operating parameters specified to be monitored in section (7) of this rule as well as up-to-date, readily accessible records for periods of operation during which the parameter boundaries established during the most recent performance test are exceeded.

1. The following constitute exceedances that shall be recorded and reported under subsection (8)(F) of this rule:

A. For enclosed combustors except for boilers and process heaters with design heat input capacity of forty-four (44) megawatts (150 million British thermal units per hour) or greater, all three (3)-hour periods of operation during which the average combustion temperature was more than twenty-eight degrees Celsius (28 °C) below the average combustion temperature during the most recent performance test at which compliance with subparagraph (3)(B)2.C. of this rule was determined; and

B. For boilers or process heaters, whenever there is a change in the location at which the vent stream is introduced into the flame zone as required under paragraph (9)(B)3. of this rule.

2. Each owner or operator subject to the provisions of this rule shall keep up-to-date, readily accessible continuous records of the indication of flow to the control device or the indication of bypass flow or records of monthly inspections of car-seals or lock-and-key configurations used to seal bypass lines, specified under section (7) of this rule.

3. Each owner or operator subject to the provisions of this rule who uses a boiler or process heater with a design heat input capacity of forty-four (44) megawatts or greater to comply with subparagraph (3)(B)2.C. of this rule shall keep an up-to-date, readily accessible record of all periods of operation of the boiler or process heater. (Examples of such records could include records of steam use, fuel use, or monitoring data collected pursuant to other state or local regulatory requirements.)

4. Each owner or operator seeking to comply with the provisions of this rule by use of an open flare shall keep up-to-date, readily accessible continuous records of the flame or flare pilot flame monitoring specified under subsection (7)(C) of this rule and up-to-date, readily accessible records of all periods of operation in which the flame or flare pilot flame is absent;

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-6.020 Definitions and Common Reference Tables **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2246–2260). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received no comments on the proposed amendment.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-6.310 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2260–2269). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received five (5) comments from three (3) sources on this rule amendment: a representative for the Missouri solid waste industry and the Environmental Industry Association, an attorney representing the IESI Corporation, and the U.S. Environmental Protection Agency (EPA).

Due to the similarity in the following two (2) comments, one (1) response that addresses these comments is at the end of these two (2) comments:

COMMENT #1: The representative for the Missouri solid waste industry and the Environmental Industry Association commented that the industry was not aware of this regulation until it was sent out electronically a few days before the *Missouri Register* came out. In the future it is expected that programs within the department would make each other aware of rulemakings in development so that involved companies can work with staff a little earlier.

COMMENT #2: The attorney representing IESI Corporation commented that he echoed the comments made by the representative for the solid waste industry about involving industry early on in rulemakings before seeing rule actions published in the *Missouri Register*. However, the proposed amendments should be adopted to bring Missouri into compliance with the federal laws. They believe they are already in compliance with these proposed changes because they already meet the federal New Source Performance Standards.

RESPONSE: The Air Program regrets these commenters were not aware of this rulemaking earlier. This rulemaking simply updated state rules for consistency with federal requirements. The Air Program communicated the proposed rulemaking with industry in general and other stakeholders via the Air Forum email listserv and within the department through the rulemaking process prior to filing with the secretary of state on September 26, 2011. The proposed rulemaking was made available for public review and comment by publishing in the *Missouri Register* and posting on the Air Program's Rulemakings on Public Notice webpage on November 1, 2011. However, based on these comments the Air Program is evaluating how to better communicate rulemakings with industry and other programs within the department beyond our current activities. No wording changes have been made to the rule text as a result of this comment.

COMMENT #3: EPA commented for rule 10 CSR 10-5.490 that a reference to the Clean Air Act found in section (1) should be corrected to the *Code of Federal Regulations*.

RESPONSE AND EXPLANATION OF CHANGE: Since rule 10 CSR 10-6.310 also contains a similar reference to the Clean Air Act in section (1) of the rule and both rule amendments were presented together, EPA's comment on 10 CSR 10-5.490 is also applicable to 10 CSR 10-6.310. Therefore, the last sentence in subsection (1)(D) has been revised to reference the *Code of Federal Regulations*.

COMMENT #4: EPA commented that section (3) incorporates by reference the *Code of Federal Regulations* (CFR) as of June 30th. EPA believes the more appropriate date would be July 1st to specifically reference the *Code of Federal Regulations* compilation date.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subsection (3)(C) rule text has been revised to change the June 30th date to July 1st.

COMMENT #5: EPA commented that subsection (3)(C) was added and discusses incorporation by reference. The EPA does not believe that the reference to 40 CFR 52.21, is relevant to this rule because it relates to the Prevention of Significant Deterioration program and is not relevant for municipal solid waste landfills.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subsection (3)(C) rule text has been revised to indicate that certain references to the department should be used in place of the federal counterpart for incorporating federal regulations in the state rule.

10 CSR 10-6.310 Restriction of Emissions From Municipal Solid Waste Landfills

(1) Applicability.

(D) For purposes of obtaining an operating permit under Title V of the Clean Air Act, the owner or operator of an MSW landfill subject to this rule with a design capacity less than two and one-half (2.5) million megagrams or two and one-half (2.5) million cubic meters is not subject to the requirements to obtain an operating permit for the landfill under 40 *Code of Federal Regulations* (CFR) 70 or 71, unless the landfill is otherwise subject to either 40 CFR 70 or 71. For purposes of submitting a timely application for an operating permit under 40 CFR 70 or 71, the owner or operator of an MSW landfill subject to the rule with a design capacity greater than or equal to two and one-half (2.5) million megagrams and two and one-half (2.5) million cubic meters on the effective date of EPA approval of the state's program under section 111(d) of the Clean Air Act (June 23, 1998), and not otherwise subject to either 40 CFR 70 or 71, becomes subject to the requirements of 40 CFR 70.5(a)(1)(i) or 71.5(a)(1)(i) ninety (90) days after the effective date of such 111(d) program approval, even if the design capacity report is submitted earlier.

(3) Standards for Air Emissions from Municipal Solid Waste Landfills. Provisions of 40 CFR 51, 40 CFR 52, 40 CFR 60, and 40 CFR 258 are incorporated by reference in subsection (3)(C) of this rule. Also, the *Compilation of Air Pollutant Emission Factors, Volume I: Stationary Point and Area Sources*, AP-42, Fifth Edition, January 1995 (hereafter AP-42), as published by the Government Printing Office, 732 North Capitol Street NW, Washington, DC 20401, shall apply and is hereby incorporated by reference, including Supplement E dated November 1998. This rule does not incorporate any subsequent amendments or additions.

(C) The specific citations of 40 CFR 51, 40 CFR 52, 40 CFR 60, and 40 CFR 258 referenced in this rule and published July 1, 2011, shall apply and are hereby incorporated by reference in this rule, as published by the Office of the Federal Register, U.S. National Archives and Records, 700 Pennsylvania Avenue NW, Washington, DC 20408. This rule does not incorporate any subsequent amendments or additions. Certain terms used in 40 CFR refer to federal officers and agencies. The following terms applicable to Missouri shall be substituted where appropriate for the delegable federal counterparts: Director shall be substituted for Administrator, and Missouri Department of Natural Resources shall be substituted for EPA, EPA Regional Office, or Environmental Protection Agency:

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-6.400 Restriction of Emission of Particulate Matter From Industrial Processes **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2269–2270). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received no comments on the proposed amendment.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under section 327.041, RSMo Supp. 2011, the board amends a rule as follows:

20 CSR 2030-2.040 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2701). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on the proposed amendment.

COMMENT #1: A comment was submitted by Chris Davis on behalf of AIA Missouri. The comment was in support of the change; however, it was suggested that the amendment be further clarified to reflect the 2012 International Building Code, Section 107 so that there would be a reference to the latest code version.
RESPONSE AND EXPLANATION OF CHANGE: The board reviewed the comment and agreed that the proposed amendment should be revised to make reference to the 2012 International Building Code instead of the 2009 version.

20 CSR 2030-2.040 Standard of Care

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 2012 edition of the International Building Code, Section 107.

(1) The board shall use, in the absence of any local building code, Section 107 only of the 2012 edition of the *International Building Code*, not including or applying any other sections referenced within Section 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*, 2012 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 (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.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under sections 327.041 and 327.411, RSMo Supp. 2011, the board amends a rule as follows:

20 CSR 2030-2.050 Title Block **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2701). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under section 327.041, RSMo Supp. 2011, and section 327.261, RSMo 2000, the board amends a rule as follows:

20 CSR 2030-11.015 Continuing Professional Competency for Professional Engineers **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2701–2702). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under sections 327.041 and 327.621, RSMo Supp. 2011, and sections 41.946 and 327.171, RSMo 2000, the board amends a rule as follows:

20 CSR 2030-11.035 Continuing Education for Landscape Architects **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2702). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under section 327.041, RSMo Supp. 2011, the board rescinds a rule as follows:

20 CSR 2030-14.050 Definition of Degree in Science as Used in Section 327.391, RSMo **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2702–2703). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2145—Missouri Board of Geologist Registration
Chapter 1—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Geologist Registration under section 256.465.2., RSMo Supp. 2011, the board amends a rule as follows:

20 CSR 2145-1.040 Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 3, 2012 (37 MoReg 45–47). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-1.010 General Organization **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2711–2712). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-1.020 Public Records **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2712). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2712–2719). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that definitions for "active employee" and "long-term disability" should be added to the rule and definitions for survivor, terminated vested subscriber, and vested subscriber need clarification without referencing another rule.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, definitions for "active employee" and "long-term disability subscriber" were added, the definitions for survivor, terminated vested subscriber, and vested subscriber have been clarified, and definitions and citations have been renumbered as needed.

COMMENT #2: The Missouri State Medical Association (MSMA), commented that, under the definition of "doctor/physician," psychiatrists do not need to be listed separately, as a psychiatrist is a doctor of medicine or doctor of osteopathy. MSMA also commented that the definition of "provider" includes "therapist with a PhD or Master's Degree in Psychiatry," when there are no PhD or masters degree in psychiatry.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, psychiatrist is removed from the definition of "doctor/physician," as a psychiatrist is already included in doctor of medicine or doctor of osteopathy, and the definition of provider is amended to include a "therapist with a PhD or Master's Degree in Psychology or Counseling."

22 CSR 10-2.010 Definitions

(2) Active employee. A benefit-eligible person employed by the state or agency of the state who meets the plan eligibility requirements.

(3) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

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

(5) Adverse benefit determination. 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.

(6) Allowable amount. 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 (8)).

(7) 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) 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.

(9) Benefits. Health care services covered by the plan.

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

(11) Cancellation of coverage. The ending of medical, dental, or vision coverage per a subscriber's voluntary request.

(12) Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

(13) Claims administrator. An organization or group responsible for the processing of claims and associated services for a health plan.

(14) Coinsurance. 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.

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

(16) Copayment. 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.

(17) Date of service. Date medical services are received.

(18) Deductible. 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.

(19) Disease management. A program offered to members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

(20) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:
(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental medicine, including dental surgery;
(H) Doctor of dentistry; or
(I) 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.

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

(22) Eligibility date. The first day a member is qualified to enroll for coverage as described in 22 CSR 10-2.020(2).

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

(24) Emergency medical condition. 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.

(25) 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 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.

(26) Employee. A benefit-eligible person employed by the state and present and future retirees from state employment who meet the plan-eligibility requirements.

(27) Employer. The state department or agency that employs the eligible employee.

(28) 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;

(H) Laboratory services—lab and 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.

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

(30) 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.

(31) 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—

(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.

(32) Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager and covered by the plan administrator.

(33) 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.

(34) Health assessment (HA). A questionnaire about a member's health and lifestyle habits required for participation in the Lifestyle Ladder program.

(35) 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.

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

(37) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered an illness.

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

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

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

(41) Long-term disability subscriber. A subscriber eligible for long-term disability coverage from Missouri State Employees' Retirement System (MOSERS), Missouri Department of Transportation and Highway Patrol Employees' Retirement System (MPERS), or another retirement system whose members are grandfathered for coverage under the plan by law.

(42) MCHCPid. An individual MCHCP member identifier used for member verification and validation.

(43) myMCHCP. A secure MCHCP member website that allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites.

(44) 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.

(45) 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 health care provider.

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

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

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

(49) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.

(50) Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

(51) Out-of-pocket maximum. 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.

(52) Participant. Shall have the same meaning as the term member defined herein (see member, section (47)).

(53) 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.

(54) 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.

(55) Plan year. The period of January 1 through December 31.

(56) 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.

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

(58) Primary care physician (PCP). An internist, family/general practitioner, or pediatrician.

(59) Prior authorization. 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.

(60) 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(20). 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 his/her license in the state in which s/he practices 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;

(F) Licensed Clinical Social Worker;

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

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

(62) 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.

(63) 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(2)(D) and is currently receiving a monthly

retirement benefit from a retirement system listed in such rule.

(64) 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.

(65) 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.

(66) Specialty medications. High cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

(67) State. Missouri.

(68) 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.

(69) 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 member and recover the money directly from the other insurer.

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

(71) Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree.

(72) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

(73) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

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

(75) 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.

(76) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

(77) Vendor. The current applicable third-party administrators of MCHCP benefits.

(78) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.020 General Membership Provisions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2719–2720). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.020 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2720–2729). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received thirteen (13) comments on the proposed rule.

COMMENT #1: MCHCP staff commented that, under part (2)(B)1.A.(I) and paragraphs (3)(B)1. and (3)(C)1., clarification is needed that these sections apply to active employees, not all employees.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under part (2)(B)1.A.(I) and paragraphs (3)(B)1. and (3)(C)1. that those sections only apply to active employees and not to all employees.

COMMENT #2: MCHCP staff commented that, under subpart (2)(B)1.B.(I)(e), clarification is needed that foster children are still eligible for coverage if the foster child relationship was in effect between the child and subscriber or spouse when the child aged out.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subpart (2)(B)1.B.(I)(e) that foster children are still eligible for coverage if the foster child relationship was in effect between the child and subscriber or spouse when the child was aged out.

COMMENT #3: MCHCP staff commented that, under part (2)(B)1.B.(I), clarification is needed that a child under the age twenty-six (26) who is a state employee may be covered as a dependent of a state employee.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under part (2)(B)1.B.(I) that a child under the age twenty-six (26) who is a state employee may be covered as a dependent of a state employee.

COMMENT #4: MCHCP staff commented that, under subparagraph (2)(D)1.C., clarification is needed to reword the sentence to clearly explain how a retiree's spouse who is a state employee may transfer coverage.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, subparagraph (2)(D)1.C. was reworded to clearly explain how a retiree's spouse who is a state employee may transfer coverage.

COMMENT #5: MCHCP staff commented that, under paragraph (2)(D)4., clarification is needed that a survivor of a terminated vested subscriber may continue coverage as a dependent if they had MCHCP coverage as a dependent at the time of the employee's death and that this section does not apply to a long-term disability survivor.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (2)(D)4. that a survivor of a terminated vested subscriber may continue coverage as a dependent if he/she had MCHCP coverage as a dependent at the time of the employee's death, and that this section does not apply to a long-term disability survivor.

COMMENT #6: MCHCP staff commented that, under subparagraph (2)(D)5.A., clarification is needed that a terminated vested employee may transfer to a spouse's coverage, not a vested employee.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subparagraph (2)(D)5.A. that a terminated vested employee may transfer to a spouse's coverage and that an active vested employee could not.

COMMENT #7: MCHCP staff commented that, under paragraph (3)(C)4., clarification is needed that if a subscriber's spouse receives a court order for coverage of a dependent, the subscriber may enroll that dependent.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (3)(C)4. that if a subscriber's spouse receives a court order for coverage of a dependent, the subscriber may enroll that dependent.

COMMENT #8: MCHCP staff commented that, under paragraph (3)(C)5., clarification is needed that a survivor can add a dependent due to placement of a child.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (3)(C)5. that a survivor can add a dependent due to placement of a child.

COMMENT #9: MCHCP staff commented that, under paragraph (4)(A)3., clarification is needed regarding the effective dates for adoption, legal custody, and foster care.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)3. regarding the effective dates for adoption, legal custody, and foster care.

COMMENT #10: MCHCP staff commented that, under paragraph (4)(A)8., clarification is needed when coverage is effective under a qualified medical child support order.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)8. regarding when coverage is effective under a qualified medical child support order.

COMMENT #11: MCHCP staff commented that, under paragraph (5)(A)3., clarification is needed for acceptable proof of eligibility for legal custody.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (5)(A)3. regarding acceptable proof of eligibility for legal custody.

COMMENT #12: MCHCP staff commented that, under paragraph (9)(B)2., clarification is needed that when an employee cancels coverage, coverage ends on the last day of the month in which MCHCP receives the cancellation.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (9)(B)2. that when an employee cancels coverage, coverage ends on the last day of the month in which MCHCP receives the cancellation.

COMMENT #13: MCHCP staff commented that, under paragraph (10)(A)8., clarification is needed that vision is a benefit eligible to continue for an employee on military leave.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (10)(A)8. that vision was included as a benefit eligible to continue for an employee on military leave.

22 CSR 10-2.020 General Membership Provisions

(2) Eligibility Requirements.
(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 active 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 (1) 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 (1) 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 (1) 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. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;
(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);

(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); or

(k) A child under the age of twenty-six (26) who is a state employee may be covered as a dependent of a state employee.

(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.

(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 (2) 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 retired employee's spouse is a state employee (active or retired), the retired employee's spouse may transfer to 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 terminated vested subscriber may continue coverage if the survivor had MCHCP coverage as a dependent 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 terminated vested employee's spouse is a state employee (active or retired), the terminated 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.

(3) Enrollment Procedures.

(B) Open Enrollment.

1. An active 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 active 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 or subscriber's spouse 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, adopts a child, or a child is placed with survivor, the dependent must be added within thirty-one (31) days of birth, adoption, placement, 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 dependents' 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 prior to the eligibility date for an adoption or placement of children, coverage becomes effective on the eligibility date;

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

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

G. Foster care. If enrollment by an employee is made due to placement of a foster child in the employee's care within thirty-one (31) days of placement, the effective date for coverage 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. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order 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 or legal custody of dependent(s)	Court-documented guardianship or custody papers listing member as guardian or custodian (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

(9) Continuation of Coverage.

(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 in which MCHCP received the cancellation.

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.

(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 for 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, vision, 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.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.030 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2730–2733). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that clarification is needed on how the MCHCP contribution for retirees is calculated.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment the calculation for the MCHCP contribution was clarified.

22 CSR 10-2.030 Contributions

(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%). For Medicare retirees, the computed percentage is multiplied by the PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the PPO 600 Plan total premium with 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.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.045 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2734–2735). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that it is not clear that cardiac rehabilitation and pulmonary rehabilitation are both eligible for thirty-six (36) visits within a twelve- (12-) week period.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, this rule was amended to clarify that cardiac rehabilitation and pulmonary rehabilitation are both eligible for thirty-six (36) visits within a twelve- (12-) week period.

22 CSR 10-2.045 Plan Utilization Review Policy

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent use whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care to reduce trauma and restorative services when the result of accidental injury;

K. Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

L. Genetic testing or counseling;

M. Home health care and palliative services;

N. Hospice care;

O. Hospital inpatient services except for observation stays;

P. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

Q. Nutritional counseling after three (3) sessions annually;

R. Orthotics over one thousand dollars ($1,000);

S. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

T. Procedures with codes ending in "T";

U. Prostheses over one thousand dollars ($1,000);

V. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

W. Skilled nursing facility;

X. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

Y. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

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Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.051 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2735–2738). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(9) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.052 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2739–2741). Those sections with changes are

reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges

(3) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(8) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.053 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2742–2745). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges

(10) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2746–2748). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2749). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.055 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2749–2755). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed rule.

COMMENT: MCHCP staff commented that clarification is needed that preventive colorectal screening will be covered in compliance with federal law.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, this rule was amended to clarify that preventive colorectal screening will be covered in compliance with federal law.

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges

(2) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(F) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically-significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially-designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral 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 are covered with a forty thousand dollar ($40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically-necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve- (12-) week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically-necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are

not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

13. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If admitted to hospital, may be required to transfer to network facility for maximum benefit;

14. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

18. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

19. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

20. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchored Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

21. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

22. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

23. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

24. Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association *Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the

requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multi-disciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor;

25. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian, with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider;

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets—covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

32. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal Screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza)—The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out of network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically-necessary preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically-necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically-necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related;

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve- (12-) week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation. Direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Allogenic bone marrow—one hundred forty three thousand dollars ($143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars ($121,000);

(III) Heart—one hundred twenty-eight thousand dollars ($128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars ($133,000);

(V) Lung—one hundred fifty-one thousand dollars ($151,000);

(VI) Kidney—Fifty-four thousand dollars ($54,000);

(VII) Kidney and pancreas—ninety-seven thousand dollars ($97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars ($153,000);

38. Urgent care. Services 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's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2756–2759). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.070 Coordination of Benefits **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2760–2761). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.075 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2761–2764). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that the effective date of plan selection changes requested through appeal to the board should be reconsidered.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the specific effective date of plan selection changes of February 1 has been removed from the rule because the effective date may vary depending upon the specific plan change requested.

22 CSR 10-2.075 Review and Appeals Procedure

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.090 Pharmacy Benefit Summary **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2764–2768). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.092 Dental Benefit Summary **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2769–2770). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.092 Dental Coverage **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2770–2771). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.093 Vision Benefit Summary **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2772). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.093 Vision Coverage **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2772–2773). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.095 TRICARE Supplement Plan **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2776–2777). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.100 Fully-Insured Medical Plan Provisions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2778). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2778–2785). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that a definition for "active employee" should be added to clarify the difference between current employees and retirees.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, a definition for "active employee" was added and definitions and citations were renumbered as needed.

COMMENT #2: The Missouri State Medical Association (MSMA), commented that, under the definition of "doctor/physician," psychiatrists do not need to be listed separately, as a psychiatrist is a doctor of medicine or doctor of osteopathy. MSMA also commented that the definition of "provider" includes "therapist with a PhD or Master's Degree in Psychiatry," when there are no PhD or masters degree in psychiatry.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, psychiatrist is removed from the definition of "doctor/physician," as a psychiatrist is already included in doctor of medicine or doctor of osteopathy, and the definition of provider is amended to include a "therapist with a PhD or Master's Degree in Psychology or Counseling."

22 CSR 10-3.010 Definitions

(2) Active employee. A benefit-eligible person employed by a public entity who meets the plan eligibility requirements.

(3) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

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

(5) Adverse benefit determination. 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 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.

(6) Allowable amount. 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 (8)).

(7) 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) 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.

(9) Benefits. Health care services covered by the plan.

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

(11) Cancellation of coverage. The ending of medical, dental, or vision coverage per a subscriber's voluntary request.

(12) Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

(13) Claims administrator. An organization or group responsible for the processing of claims and associated services for a health plan.

(14) Coinsurance. 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.

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

(16) Copayment. 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.

(17) Date of service. Date medical services are received.

(18) Deductible. 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.

(19) Disease management. A program offered to members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

(20) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;

(B) Doctor of osteopathy;

(C) Podiatrist;

(D) Optometrist;

(E) Chiropractor;

(F) Psychologist;

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

(H) Doctor of dentistry; or

(I) 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.

(21) Effective date. The date on which coverage takes effect as described in 22 CSR 10-3.020(4).

(22) Eligibility date. The first day a member is qualified to enroll for coverage as described in 22 CSR 10-3.020(2).

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

(24) Emergency medical condition. 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.

(25) 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 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.

(26) Employee. A benefit-eligible person employed by a participating public entity and present and future retirees from the participating public entity who meet the plan-eligibility requirements.

(27) Employer. The public entity that employs the eligible employee.

(28) 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;

(H) Laboratory services—lab and 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.

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

(30) 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.

(31) 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—

(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.

(32) Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager and covered by the plan administrator.

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

(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.

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

(36) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered an illness.

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

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

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

(40) MCHCPid. An individual MCHCP member identifier used for member verification and validation.

(41) myMCHCP. A secure MCHCP member website that allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites.

(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.

(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 health care provider.

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

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

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

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

(48) Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

(49) Out-of-pocket maximum. 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.

(50) Participant. Shall have the same meaning as the term member defined herein (see member, section (45)).

(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.

(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.

(53) Plan year. The period of January 1 through December 31.

(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.

(56) Primary care physician (PCP). An internist, family/general practitioner, or pediatrician.

(57) Prior authorization. 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.

(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 10-3.010(20). 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 his/her license in the state in which s/he practices 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;

(F) Licensed Clinical Social Worker;

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

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

(60) Public entity. A state-sponsored institution of higher learning, political subdivision, or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.

(61) 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.

(62) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(2)(D) and is currently receiving a monthly retirement benefit from a public entity.

(63) 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.

(64) 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.

(65) Specialty medications. High cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

(66) State. Missouri.

(67) 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.

(68) 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 member and recover the money directly from the other insurer.

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

(70) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

(71) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

(72) Vendor. The current applicable third-party administrators of MCHCP benefits.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2785). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.020 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2785–2793). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received nine (9) comments on the proposed rule.

COMMENT #1: MCHCP staff commented that, under section (2), for clarification what the eligibility requirements are, subsection (2)(B) should be renumbered paragraph (2)(A)1. with the old subsection paragraph (2)(A)1. renumbered paragraph (2)(A)2.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, to clarify subsection (2)(B), was renumbered paragraph (2)(A)1. with the old paragraph (2)(B)1. renumbered paragraph (2)(A)2.

COMMENT #2: MCHCP staff commented that, under subpart (2)(B)1.B.(I)(e), clarification is needed that foster children are still eligible for coverage if the foster child relationship was in effect between the child and subscriber or spouse when the child aged out.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subpart (2)(A)2.B.(I)(e) that foster children are still eligible for coverage if the foster child relationship was in effect between the child and subscriber or spouse when the child was aged out.

COMMENT #3: MCHCP staff commented that, under paragraph (3)(B)1. and paragraph (3)(C)1., clarification is needed that employee should be active employee as those sections do not apply to retirees.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (3)(B)1. and paragraph (3)(C)1. that those paragraphs apply to active employees.

COMMENT #4: MCHCP staff commented that, under paragraph (3)(C)3., survivors are not included in public entity and thus should be removed from this section.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, survivors was removed from paragraph (3)(C)3. as survivors are not included in the public entity plan benefits.

COMMENT #5: MCHCP staff commented that, under paragraph (3)(C)4., clarification is needed that if a subscriber's spouse receives a court order for coverage of a dependent, the subscriber may enroll that dependent.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (3)(C)4. that if a subscriber's spouse receives a court order for coverage of a dependent, the subscriber may enroll that dependent.

COMMENT #6: MCHCP staff commented that, under paragraph (4)(A)3., clarification is needed regarding the effective dates for adoption, legal custody, and foster care.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification under paragraph (4)(A)3. was made regarding the effective dates for adoption, legal custody, and foster care.

COMMENT #7: MCHCP staff commented that, under paragraph (4)(A)6., clarification is needed when coverage is effective under a qualified medical child support order.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)6., when coverage is effective under a qualified medical child support order.

COMMENT #8: MCHCP staff commented that, under paragraph (5)(A)3., clarification is needed for acceptable proof of eligibility for legal custody.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (5)(A)3. regarding acceptable proof of legal custody.

COMMENT #9: MCHCP staff commented that, under paragraph (9)(A)8., clarification is needed that vision is a benefit that is eligible to continue for an employee on military leave.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (9)(A)8. that vision was included as a benefit that is eligible to continue for an employee on military leave.

22 CSR 10-3.020 General Membership Provisions

(2) Eligibility Requirements.

(A) Employee and Dependent Eligibility Requirements. Health plans contracted with MCHCP must be made available to all eligible employees, their dependents, and retirees of the public entity. An eligible employee is one who is actively employed and meets the minimum number of hours worked per year as established by his/her employer. If the public entity allows elected/appointed officials to participate in medical coverage, the definition of an employee includes elected/appointed officials where applicable. The entity will determine the eligibility requirements of waiting periods, required number of working hours, pay status, and contribution levels.

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

2. An eligible employee may enroll eligible dependents as long as the eligible employee is also enrolled. Eligible dependents include:

A. Spouse.

(I) A public entity retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(II) If one (1) 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 (1) 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 (1) 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. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(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.

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

(C) Retiree and Dependent Eligibility Requirements. A retiree and his/her dependents will remain eligible as long as the entity remains with MCHCP.

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

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

(I) 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.

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

3. A retiree may only add dependents to his/her coverage when—

A. A life event occurs; or

B. A dependent's employer-sponsored coverage ends due to one (1) of the following, provided that the dependent's employer-sponsored coverage was in place for twelve (12) months immediately prior to the loss, and MCHCP coverage is requested within sixty (60) days of the termination date of the previous coverage:

(I) Termination of employment;

(II) Retirement; or

(III) Termination of group coverage by the employer.

4. A retiree and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

(3) Enrollment Procedures.

(B) Open Enrollment.

1. An active 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 may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree 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 active 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, and the coverage was in place for twelve (12) months immediately prior to the loss:

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

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. A retiree 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 may enroll his/her dependent within sixty (60) days if the dependent involuntarily loses employer-sponsored coverage under one (1) of the following circumstances. Dependent employer-sponsored coverage must be in place for twelve (12) months immediately prior to the loss, and MCHCP coverage must be requested within sixty (60) days of the termination date of the previous coverage:

(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 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 or a subscriber's spouse receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent(s) in an MCHCP plan within sixty (60) days of the court order.

5. 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 eligible dependent(s), or an employee rehired after his/her coverage terminates, and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date as determined by the employer.

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 and applicable waiting period. 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 prior to the eligibility date for an adoption or placement of children, coverage becomes effective on the eligibility date;

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

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

G. Foster care. If enrollment by an employee is made due to placement of a foster child in the employee's care within thirty-one (31) days of placement, the effective date for coverage 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. When a dependent of a subscriber first becomes eligible, coverage will become effective on the eligibility date or the first day of the month coinciding with or after the eligibility date if enrollment is made within thirty-one (31) days of the eligibility date.

6. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility.

(A) A public entity is required to obtain and keep on file proof of eligibility for dependents enrolled in a MCHCP medical, dental, and/or vision plan. Proof of eligibility documentation is required for all dependents.

1. Notification of the proof of eligibility policy will occur during the September 2012 public entity payroll representatives' informational meetings. Initial time frame for a public entity to obtain proof of eligibility documentation will occur September 1, 2012, through November 29, 2012.

2. Proof of eligibility must be obtained within thirty-one (31) days for a newly enrolled dependent and within ninety (90) days from date of birth for a newborn.

3. Coverage is provided for a newborn of a member from the moment of birth. The public entity or member must notify the plan of the birth verbally or in writing within thirty-one (31) days of the birth date. The plan will notify the public entity and 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.

4. MCHCP reserves the right to request proof of eligibility be provided at any time. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will be terminated or will not take effect.

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

6. 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 or legal custody of dependent(s)	Court-documented guardianship or custody papers listing member as guardian or custodian (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

7. Annually, MCHCP will require a signed attestation form verifying receipt of proof of eligibility from the public entity with enrolled dependents. A blank attestation form will be delivered to the public entity prior to open enrollment. Instructions to complete the form, filing requirements, and deadlines will accompany the attestation form.

(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 public entity 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 pre-dates 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.

(9) 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 for 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, vision, 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.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2794–2797). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.045 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2798–2799). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that it is not clear that cardiac rehabilitation and pulmonary rehabilitation are both eligible for thirty-six (36) visits within a twelve- (12-) week period.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, this rule was amended to clarify that cardiac rehabilitation and pulmonary rehabilitation are both eligible for thirty-six (36) visits within a twelve- (12-) week period.

22 CSR 10-3.045 Plan Utilization Review Policy

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent use whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care to reduce trauma and restorative services when the result of accidental injury;

K. Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

L. Genetic testing or counseling;

M. Home health care and palliative services;

N. Hospice care;

O. Hospital inpatient services except for observation stays;

P. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

Q. Nutritional counseling after three (3) sessions annually;

R. Orthotics over one thousand dollars ($1,000);

S. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

T. Procedures with codes ending in "T";

U. Prostheses over one thousand dollars ($1,000);

V. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

W. Skilled nursing facility;

X. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

Y. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.053 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2799–2802). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

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

(4) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(7) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.054 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2803–2805). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable

charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

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

(4) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(7) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.055 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2806–2808). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

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

(8) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.056 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2809–2811). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(6) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2812). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.057 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2812–2818). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed rule.

COMMENT: MCHCP staff commented that clarification is needed that preventive colorectal screening will be covered in compliance with federal law.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, this rule was amended to clarify that preventive colorectal screening will be covered in compliance with federal law.

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges

(2) Covered Charges Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.

(F) Plan benefits for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically-significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially-designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral 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 are covered with a forty thousand dollar ($40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically-necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve- (12-) week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of

disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically-necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

13. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If admitted to hospital, may be required to transfer to network facility for maximum benefit;

14. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

18. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

19. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

20. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

21. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

22. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent, or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

23. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

24. Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association *Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor;

25. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian, with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider;

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets—covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

32. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be

coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza). The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out-of-network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically-necessary preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically-necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically-necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related;

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve- (12-) week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation. Direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Allogenic bone marrow—one hundred forty three thousand dollars ($143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars ($121,000);

(III) Heart—one hundred twenty-eight thousand dollars ($128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars ($133,000);

(V) Lung—one hundred fifty-one thousand dollars ($151,000);

(VI) Kidney—Fifty-four thousand dollars ($54,000);

(VII) Kidney and pancreas—ninety-seven thousand dollars ($97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars ($153,000);

38. Urgent care. Services 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's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Limitations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2819–2822). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.070 Coordination of Benefits **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2823–2824). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.075 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2824–2827). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that the effective date of plan selection changes requested through appeal to the board should be reconsidered.

RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the specific effective date of plan selection changes of February 1 has been removed from the rule because the effective date may vary depending upon the specific plan change requested.

22 CSR 10-3.075 Review and Appeals Procedure

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.090 Pharmacy Benefit Summary **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2827–2831). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-3.092 Dental Benefit Summary **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2832). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.092 Dental Coverage **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2832–2834). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-3.093 Vision Benefit Summary **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2835). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.093 Vision Coverage **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2835–2836). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.100 Fully-Insured Medical Plan Provisions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2837). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is a list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. In addition, this list includes contractor(s) that have agreed to placement on the list maintained by the Secretary of State pursuant to Section 290.330 as a part of the resolution of criminal charges of violating the Missouri Prevailing Wage Law. Under this statute, no public body shall award a contract for public works to any contractor or subcontractor, or simulation thereof, during the time that such contractor or subcontractor's name appears on this state debarment list maintained by the Secretary of State.

Contractors Convicted of Violations of the Missouri Prevailing Wage Law

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Rycoblake Corp. Case No. 0916-CR03145 (Jackson County Cir. Ct.)		4212 SE Saddlebrook Cir Lee's Summit, MO 64082	7/13/11	7/13/11 to 7/13/12

Contractors Agreeing to Placement on the Public Works Debarment List as Part of an Agreement Relating to Criminal Pleas

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Rycoblake Corp.		4212 SE Saddlebrook Cir Lee's Summit, MO 64082		7/13/11 to 12/1/12
Gerald Chevalier		4212 SE Saddlebrook Cir Lee's Summit, MO 64082		7/13/11 to 12/1/12

Dated this 2 day of August 2011.

Carla Buschjost

Carla Buschjost, Director

ADDITION TO STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to Mr. Saxon W. Johnson, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. Saxon W. Johnson including The Tile Doctor or (3) to any other simulation of Mr. Saxon W. Johnson or of The Tile Doctor for a period of one year, or until September 2, 2012.

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Saxon W. Johnson DBA The Tile Doctor Case No. 10CA-CR01318 Cass County Cir. Ct.		10724 Haskins Ct Shawnee Mission, KS 66210	9/2/2011	9/2/2011-9/2/2012

Dated this 13 day of September 2011.

Carla Buschjost, Director

ADDITION TO STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to Mr. Larry G. McElroy, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. Larry G. McElroy including Blackhawk or (3) to any other simulation of Mr. Larry G. McElroy or of Blackhawk Electric for a period of one year, or until December 27, 2012.

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Larry G. McElroy DBA Blackhawk Electric Case No. 11CG-CR01157 Cape Girardeau County Cir. Ct.		254 E. Lake Dr., PO Box 248 Cape Girardeau, MO 63701	12/27/2011	12/27/2011-12/27/2012

Dated this 26 day of January, 2012.

Carla Buschjost, Director

ADDITION TO STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to Mr. Norman Bass, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. Norman Bass including Municipal Construction Incorporated or (3) to any other simulation of Mr. Norman Bass or of Municipal Construction Incorporated for a period of one year, or until February 1, 2013.

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Norman Bass DBA Municipal Construction Incorporated Case No. 12SO-CR00103 Scott County Cir. Ct.		10150 Hawthorne Ridge Goodrich, MI 48438	2/01/12	2/01/2012-2/01/2013

Dated this 17 day of February, 2012.

Carla Buschjost, Director

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to dissolutions@sos.mo.gov.

NOTICE OF WINDING UP AND DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST HOPELAND PROPERTIES-EAU CLAIRE, LLC.

On February 27, 2012, Hopeland Properties-Eau Claire, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up and Articles of Termination with the Missouri Secretary of State. The Company requests that claimants against the Company present claims in writing to: James A. Fredericks, Attorney c/o Polsinelli Shughart PC, 100 South Fourth Street, Suite 1000, St. Louis, MO 63102. All claims must include (1) the name, address and telephone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF WINDING UP AND DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST HOPELAND WAREHOUSE, LLC.

On February 27, 2012, Hopeland Warehouse, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up and Articles of Termination with the Missouri Secretary of State. The Company requests that claimants against the Company present claims in writing to: James A. Fredericks, Attorney c/o Polsinelli Shughart PC, 100 South Fourth Street, Suite 1000, St. Louis, MO 63102. All claims must include (1) the name, address and telephone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF WINDING UP AND DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST KEYSTONE FAMILY GENERAL PARTNER, LLC.

On March 7, 2012, Keystone Family General Partner, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up and Articles of Termination with the Missouri Secretary of State. The Company requests that claimants against the Company present claims in writing to: Kim Brown, Attorney c/o Polsinelli Shughart PC, 100 South Fourth Street, Suite 1000, St. Louis, MO 63102. All claims must include (1) the name, address and telephone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST MID-WEST PROPANE AND REFINED FUELS, L.L.C.

On March 1, 2012, Mid-West Propane and Refined Fuels, L.L.C., a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o Matthew M. Krohn, Esq., Andereck, Evans, Widger, Johnson & Lewis, L.L.C., 9th & Washington Streets, P.O. Box 547, Trenton, MO 64683, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number, 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last filing or publication of this Notice.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST SOUTH BEACH TANNING FANTASY, L.L.C.

On March 13, 2012, SOUTH BEACH TANNING FANTASY, L.L.C., a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o C. Bradford Cantwell, Carnahan, Evans, Cantwell & Brown, P.C., 2805 S. Ingram Mill, Springfield, Missouri 65804, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number; 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last of filing or publication of this Notice.

NOTICE OF DISSOULUTION OF

LIMITED LIABILITY COMPANY

TO ALL CREDITORS OF AND ALL

CLAIMANTS AGAINST

THE HAMPTONS FLOORING COMPANY, L.L.C.

On March 8,2012, The Hamptons Flooring Company, L.L.C., a Missouri limited liability company (the "Company") filed a notice of Winding Up with the Missouri Secretary of State. Claims against the Company should be mailed to Scott Perkinson,1274 Bentoak Ct., Kirkwood, MO 63122. All claims must include the following information:

1. Name & address of the claimant;
2. The amount of the claim;
3. Basis for the claim; and
4. Documentation for the claim.

All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—30 (2005) and 31 (2006). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				35 MoReg 1815
	DEPARTMENT OF AGRICULTURE				
2 CSR 70-25.065	Plant Industries		This Issue		
2 CSR 70-30.110	Plant Industries		This Issue		
2 CSR 70-30.115	Plant Industries		This Issue		
2 CSR 80-1.010	State Milk Board		This Issue		
2 CSR 80-2.010	State Milk Board		37 MoReg 505R 37 MoReg 505		
2 CSR 80-2.020	State Milk Board		This Issue		
2 CSR 80-2.030	State Milk Board		This Issue		
2 CSR 80-2.040	State Milk Board		This Issue		
2 CSR 80-2.050	State Milk Board		This Issue		
2 CSR 80-2.060	State Milk Board		This Issue		
2 CSR 80-2.070	State Milk Board		This Issue		
2 CSR 80-2.080	State Milk Board		This Issue		
2 CSR 80-2.091	State Milk Board		This Issue		
2 CSR 80-2.101	State Milk Board		This Issue		
2 CSR 80-2.110	State Milk Board		This Issue		
2 CSR 80-2.121	State Milk Board		This Issue		
2 CSR 80-2.130	State Milk Board		This Issue		
2 CSR 80-2.141	State Milk Board		This Issue		
2 CSR 80-2.151	State Milk Board		This Issue		
2 CSR 80-2.161	State Milk Board		This Issue		
2 CSR 80-2.170	State Milk Board		This Issue		
2 CSR 80-2.180	State Milk Board		This Issue		
2 CSR 80-4.010	State Milk Board		This Issue		
2 CSR 90-10	Weights and Measures				36 MoReg 1762
	DEPARTMENT OF CONSERVATION				
3 CSR 10-6.415	Conservation Commission		This Issue		
3 CSR 10-7.455	Conservation Commission		36 MoReg 2161	37 MoReg 51	37 MoReg 118
3 CSR 10-11.120	Conservation Commission		This Issue		
3 CSR 10-11.180	Conservation Commission		This Issue		
3 CSR 10-12.109	Conservation Commission		This Issue		
3 CSR 10-12.110	Conservation Commission		This Issue		
3 CSR 10-12.125	Conservation Commission		This Issue		
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 170-7.010	Missouri Housing Development Commission		37 MoReg 7R		
4 CSR 170-7.020	Missouri Housing Development Commission		37 MoReg 7R		
4 CSR 170-7.030	Missouri Housing Development Commission		37 MoReg 8R		
4 CSR 170-7.040	Missouri Housing Development Commission		37 MoReg 8R		
4 CSR 170-7.050	Missouri Housing Development Commission		37 MoReg 8R		
4 CSR 170-7.100	Missouri Housing Development Commission		37 MoReg 8		
4 CSR 170-7.200	Missouri Housing Development Commission		37 MoReg 9		
4 CSR 170-7.300	Missouri Housing Development Commission		37 MoReg 10		
4 CSR 170-7.400	Missouri Housing Development Commission		37 MoReg 11		
4 CSR 170-7.500	Missouri Housing Development Commission		37 MoReg 12		
4 CSR 170-7.600	Missouri Housing Development Commission		37 MoReg 14		
4 CSR 240-4.020	Public Service Commission		36 MoReg 2230	37 MoReg 527W	
4 CSR 240-20.065	Public Service Commission		37 MoReg 315		
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 20-100.200	Division of Learning Services		37 MoReg 507		
5 CSR 20-100.250	Division of Learning Services		37 MoReg 333		
5 CSR 20-300.120	Division of Learning Services		N.A.	37 MoReg 527	
5 CSR 20-400.150	Division of Learning Services		37 MoReg 509		
5 CSR 20-400.160	Division of Learning Services		37 MoReg 509		
5 CSR 20-400.170	Division of Learning Services		37 MoReg 510		
5 CSR 20-400.180	Division of Learning Services		37 MoReg 510		
5 CSR 20-400.190	Division of Learning Services		37 MoReg 511		
5 CSR 20-400.200	Division of Learning Services		37 MoReg 511		
5 CSR 20-400.250	Division of Learning Services		37 MoReg 511		
5 CSR 20-400.260	Division of Learning Services		37 MoReg 512		
5 CSR 20-400.280	Division of Learning Services		37 MoReg 512		
5 CSR 50-378.100	Division of School Improvement		37 MoReg 97R		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
5 CSR 50-380.010	Division of School Improvement		37 MoReg 97R		
5 CSR 50-390.010	Division of School Improvement		37 MoReg 97R		
	DEPARTMENT OF TRANSPORTATION				
7 CSR 10-25.010	Missouri Highways and Transportation Commission				37 MoReg 540
	DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS				
8 CSR 10-5.030	Division of Employment Security		37 MoReg 334		
	DEPARTMENT OF MENTAL HEALTH				
9 CSR 10-5.240	Director, Department of Mental Health	37 MoReg 147	36 MoReg 2369	This Issue	
9 CSR 10-31.040	Director, Department of Mental Health		37 MoReg 335		
9 CSR 30-4.030	Certification Standards		37 MoReg 15		
9 CSR 30-4.034	Certification Standards		37 MoReg 17		
9 CSR 30-4.035	Certification Standards		37 MoReg 18		
9 CSR 30-4.039	Certification Standards		37 MoReg 19		
9 CSR 30-4.042	Certification Standards		37 MoReg 20		
9 CSR 30-4.043	Certification Standards		37 MoReg 20		
9 CSR 30-4.046	Certification Standards		37 MoReg 22		
9 CSR 45-2.010	Division of Mental Retardation and Developmental Disabilities		37 MoReg 337		
9 CSR 45-2.015	Division of Mental Retardation and Developmental Disabilities		37 MoReg 352		
9 CSR 45-2.017	Division of Mental Retardation and Developmental Disabilities		37 MoReg 355		
9 CSR 45-2.020	Division of Mental Retardation and Developmental Disabilities		37 MoReg 377		
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 10-2.385	Air Conservation Commission		36 MoReg 2520		
10 CSR 10-5.040	Air Conservation Commission		36 MoReg 2232	This Issue	
10 CSR 10-5.130	Air Conservation Commission		36 MoReg 2233	This Issue	
10 CSR 10-5.385	Air Conservation Commission		36 MoReg 2521		
10 CSR 10-5.455	Air Conservation Commission		36 MoReg 2233	This Issue	
10 CSR 10-5.490	Air Conservation Commission		36 MoReg 2234	This Issue	
10 CSR 10-6.020	Air Conservation Commission		36 MoReg 2246	This Issue	
10 CSR 10-6.060	Air Conservation Commission		37 MoReg 379		
10 CSR 10-6.065	Air Conservation Commission		37 MoReg 383		
10 CSR 10-6.260	Air Conservation Commission		37 MoReg 388		
10 CSR 10-6.310	Air Conservation Commission		36 MoReg 2260	This Issue	
10 CSR 10-6.400	Air Conservation Commission		36 MoReg 2269	This Issue	
10 CSR 10-6.410	Air Conservation Commission		37 MoReg 392		
10 CSR 20-6.010	Clean Water Commission	36 MoReg 1892	36 MoReg 1895	37 MoReg 443	
10 CSR 20-6.100	Clean Water Commission		36 MoReg 2906R 36 MoReg 2906 37 MoReg 393R 37 MoReg 394		
10 CSR 20-6.300	Clean Water Commission		36 MoReg 1909	37 MoReg 445	
10 CSR 20-7.031	Clean Water Commission		36 MoReg 2521		
10 CSR 20-8.300	Clean Water Commission		36 MoReg 1927	37 MoReg 458	
10 CSR 23-1.050	Division of Geology and Land Survey		36 MoReg 2178	37 MoReg 466	
10 CSR 60-5.010	Safe Drinking Water Commission		36 MoReg 2374	37 MoReg 528	
10 CSR 60-7.020	Safe Drinking Water Commission		36 MoReg 2375	37 MoReg 529	
10 CSR 60-8.030	Safe Drinking Water Commission		36 MoReg 2380	37 MoReg 529	
10 CSR 60-15.010	Safe Drinking Water Commission		36 MoReg 2380	37 MoReg 529	
10 CSR 60-15.020	Safe Drinking Water Commission		36 MoReg 2381	37 MoReg 529	
10 CSR 60-15.040	Safe Drinking Water Commission		36 MoReg 2384	37 MoReg 529	
10 CSR 60-15.050	Safe Drinking Water Commission		36 MoReg 2384	37 MoReg 530	
10 CSR 60-15.060	Safe Drinking Water Commission		36 MoReg 2385R 36 MoReg 2385	37 MoReg 530R 37 MoReg 530	
10 CSR 60-15.070	Safe Drinking Water Commission		36 MoReg 2391	37 MoReg 530	
10 CSR 60-15.080	Safe Drinking Water Commission		36 MoReg 2393	37 MoReg 530	
10 CSR 60-15.090	Safe Drinking Water Commission		36 MoReg 2394	37 MoReg 531	
10 CSR 140-8.010	Division of Energy		37 MoReg 513		
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 10-12.010	Adjutant General *(Changed to 11 CSR 30-13.010)*		37 MoReg 152		
11 CSR 10-12.020	Adjutant General *(Changed to 11 CSR 30-13.020)*		37 MoReg 152		
11 CSR 10-12.030	Adjutant General *(Changed to 11 CSR 30-13.030)*		37 MoReg 153		
11 CSR 10-12.040	Adjutant General *(Changed to 11 CSR 30-13.040)*		37 MoReg 153		
11 CSR 10-12.050	Adjutant General *(Changed to 11 CSR 30-13.050)*		37 MoReg 153		
11 CSR 10-12.060	Adjutant General *(Changed to 11 CSR 30-13.060)*		37 MoReg 154		
11 CSR 30-12.010	Office of the Director	37 MoReg 93	37 MoReg 98		

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11 CSR 30-13.010	Office of the Director (*Changed from 11 CSR 10-12.010)*		37 MoReg 152		
11 CSR 30-13.020	Office of the Director (*Changed from 11 CSR 10-12.020)*		37 MoReg 152		
11 CSR 30-13.030	Office of the Director (*Changed from 11 CSR 10-12.030)*		37 MoReg 153		
11 CSR 30-13.040	Office of the Director (*Changed from 11 CSR 10-12.040)*		37 MoReg 153		
11 CSR 30-13.050	Office of the Director (*Changed from 11 CSR 10-12.050)*		37 MoReg 153		
11 CSR 30-13.060	Office of the Director (*Changed from 11 CSR 10-12.060)*		37 MoReg 154		
11 CSR 30-13.070	Office of the Director		37 MoReg 155		
11 CSR 30-13.080	Office of the Director		37 MoReg 156		
11 CSR 30-13.090	Office of the Director		37 MoReg 156		
11 CSR 30-13.100	Office of the Director		37 MoReg 156		
11 CSR 30-13.110	Office of the Director		37 MoReg 157		
11 CSR 45-1.015	Missouri Gaming Commission		36 MoReg 2270	37 MoReg 531	
11 CSR 45-1.080	Missouri Gaming Commission		36 MoReg 2270	37 MoReg 531	
11 CSR 45-5.030	Missouri Gaming Commission		36 MoReg 2270	37 MoReg 531	
11 CSR 45-5.065	Missouri Gaming Commission		36 MoReg 2271	37 MoReg 532	
11 CSR 45-5.185	Missouri Gaming Commission		37 MoReg 407		
11 CSR 45-8.130	Missouri Gaming Commission		37 MoReg 408		
11 CSR 45-9.106	Missouri Gaming Commission		37 MoReg 410		
11 CSR 45-9.108	Missouri Gaming Commission		36 MoReg 2687		
11 CSR 45-9.118	Missouri Gaming Commission		37 MoReg 106		
11 CSR 45-9.120	Missouri Gaming Commission		37 MoReg 410		
11 CSR 45-12.090	Missouri Gaming Commission		36 MoReg 2271	37 MoReg 532	
	DEPARTMENT OF REVENUE				
12 CSR 10-23.446	Director of Revenue		37 MoReg 237		
12 CSR 10-26.210	Director of Revenue		37 MoReg 410		
12 CSR 10-41.010	Director of Revenue	36 MoReg 2455	36 MoReg 2687	37 MoReg 467	
12 CSR 30-4.010	State Tax Commission		37 MoReg 157		
	DEPARTMENT OF SOCIAL SERVICES				
13 CSR 40-2.395	Family Support Division		37 MoReg 517		
13 CSR 70-3.230	MO HealthNet Division		37 MoReg 23		
13 CSR 70-3.240	MO HealthNet Division		37 MoReg 106		
13 CSR 70-4.110	MO HealthNet Division		37 MoReg 111		
13 CSR 70-10.160	MO HealthNet Division		37 MoReg 441		
13 CSR 70-15.200	MO HealthNet Division		37 MoReg 27R		
13 CSR 70-35.010	MO HealthNet Division		36 MoReg 2273	37 MoReg 532	
	DEPARTMENT OF CORRECTIONS				
14 CSR 80-3.010	State Board of Probation and Parole		36 MoReg 2695	37 MoReg 536	
14 CSR 80-3.020	State Board of Probation and Parole		36 MoReg 2697	37 MoReg 536	
14 CSR 80-4.010	State Board of Probation and Parole		37 MoReg 160		
14 CSR 80-4.020	State Board of Probation and Parole		37 MoReg 160		
14 CSR 80-4.030	State Board of Probation and Parole		37 MoReg 161		
14 CSR 80-5.010	State Board of Probation and Parole		36 MoReg 2697	37 MoReg 536	
14 CSR 80-5.020	State Board of Probation and Parole		36 MoReg 2698	37 MoReg 537	
	ELECTED OFFICIALS				
15 CSR 30-200.010	Secretary of State		36 MoReg 2698	37 MoReg 467	
15 CSR 30-200.020	Secretary of State		36 MoReg 2699	37 MoReg 467	
15 CSR 40-3.020	State Auditor		37 MoReg 518		
15 CSR 40-3.030	State Auditor		37 MoReg 518		
15 CSR 40-5.010	State Auditor		37 MoReg 519R		
15 CSR 60-13.060	Attorney General		36 MoReg 2274		
	RETIREMENT SYSTEMS				
16 CSR 10-5.030	The Public School Retirement System of Missouri		37 MoReg 163		
16 CSR 10-6.090	The Public School Retirement System of Missouri		37 MoReg 164		
16 CSR 50-2.010	The County Employees' Retirement Fund		37 MoReg 165		
16 CSR 50-2.160	The County Employees' Retirement Fund		37 MoReg 165		
16 CSR 50-3.010	The County Employees' Retirement Fund		37 MoReg 165		
	DEPARTMENT OF HEALTH AND SENIOR SERVICES				
19 CSR 10-10	Office of the Director				36 MoReg 1700
19 CSR 20-26.030	Division of Community and Public Health		37 MoReg 519R		
19 CSR 20-26.040	Division of Community and Public Health		37 MoReg 519		
19 CSR 20-28.010	Division of Community and Public Health		37 MoReg 27		
19 CSR 20-28.040	Division of Community and Public Health		37 MoReg 38		
19 CSR 30-1	Division of Regulation and Licensure				36 MoReg 1702
19 CSR 30-20	Division of Regulation and Licensure				36 MoReg 1704
19 CSR 30-40.365	Division of Regulation and Licensure		37 MoReg 523		
19 CSR 30-70.620	Division of Regulation and Licensure		37 MoReg 44		

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19 CSR 30-70.630	Division of Regulation and Licensure		37 MoReg 44		
19 CSR 30-81.015	Division of Regulation and Licensure		37 MoReg 523R		
19 CSR 30-85.022	Division of Regulation and Licensure		This Issue		
19 CSR 30-86.022	Division of Regulation and Licensure		This Issue		
19 CSR 30-86.043	Division of Regulation and Licensure		37 MoReg 524		
19 CSR 30-86.047	Division of Regulation and Licensure		37 MoReg 525		
19 CSR 30-88.020	Division of Regulation and Licensure		This Issue		
19 CSR 60-50	Missouri Health Facilities Review Committee				37 MoReg 472 37 MoReg 541 37 MoReg 541 37 MoReg 541
	DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION				
20 CSR	Applied Behavior Analysis Maximum Benefit				37 MoReg 472
20 CSR	Construction Claims Binding Arbitration Cap				36 MoReg 192 37 MoReg 62
20 CSR	Sovereign Immunity Limits				37 MoReg 62
20 CSR	State Legal Expense Fund Cap				36 MoReg 192 37 MoReg 62
20 CSR 100-5.020	Insurer Conduct	36 MoReg 2897	36 MoReg 2920 37 MoReg 166		
20 CSR 200-12.030	Insurance Solvency and Company Regulation		37 MoReg 238		
20 CSR 200-18.030	Insurance Solvency and Company Regulation	37 MoReg 150	37 MoReg 168		
20 CSR 700-1.160	Insurance Licensing	37 MoReg 150	37 MoReg 171		
20 CSR 2010-2.022	Missouri State Board of Accountancy		37 MoReg 112		
20 CSR 2030-2.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2701	This Issue	
20 CSR 2030-2.050	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2701	This Issue	
20 CSR 2030-11.015	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2701	This Issue	
20 CSR 2030-11.035	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2702	This Issue	
20 CSR 2030-14.050	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2702R	This IssueR	
20 CSR 2110-2.010	Missouri Dental Board		This Issue		
20 CSR 2110-2.030	Missouri Dental Board		This Issue		
20 CSR 2110-2.050	Missouri Dental Board		This Issue		
20 CSR 2110-2.070	Missouri Dental Board		This Issue		
20 CSR 2115-1.040	State Committee of Dietitians	36 MoReg 2899	36 MoReg 2922	37 MoReg 537	
20 CSR 2115-2.010	State Committee of Dietitians		36 MoReg 2925	37 MoReg 537	
20 CSR 2115-2.020	State Committee of Dietitians		36 MoReg 2925	37 MoReg 537	
20 CSR 2115-2.040	State Committee of Dietitians		36 MoReg 2925	37 MoReg 537	
20 CSR 2115-2.045	State Committee of Dietitians		36 MoReg 2926	37 MoReg 537	
20 CSR 2145-1.040	Missouri Board of Geologist Registration		37 MoReg 45	This Issue	
20 CSR 2150-1.011	State Board of Registration for the Healing Arts		37 MoReg 173R 37 MoReg 173		
20 CSR 2150-2.150	State Board of Registration for the Healing Arts		36 MoReg 2703	37 MoReg 467	
20 CSR 2150-3.010	State Board of Registration for the Healing Arts		36 MoReg 2705	37 MoReg 467	
20 CSR 2150-3.203	State Board of Registration for the Healing Arts		37 MoReg 178		
20 CSR 2150-4.201	State Board of Registration for the Healing Arts		37 MoReg 178		
20 CSR 2150-4.203	State Board of Registration for the Healing Arts		37 MoReg 179		
20 CSR 2150-4.205	State Board of Registration for the Healing Arts		37 MoReg 180		
20 CSR 2150-5.026	State Board of Registration for the Healing Arts		37 MoReg 241		
20 CSR 2150-5.028	State Board of Registration for the Healing Arts		37 MoReg 241		
20 CSR 2150-6.010	State Board of Registration for the Healing Arts		36 MoReg 2707	37 MoReg 468	
20 CSR 2150-6.020	State Board of Registration for the Healing Arts		36 MoReg 2707	37 MoReg 468	
20 CSR 2150-6.040	State Board of Registration for the Healing Arts		36 MoReg 2709	37 MoReg 468	
20 CSR 2150-6.062	State Board of Registration for the Healing Arts		36 MoReg 2709	37 MoReg 468	
20 CSR 2165-2.050	Board of Examiners for Hearing Instrument Specialists		37 MoReg 113		
20 CSR 2205-3.010	Missouri Board of Occupational Therapy		37 MoReg 180		
20 CSR 2205-3.020	Missouri Board of Occupational Therapy		37 MoReg 184		
20 CSR 2205-3.030	Missouri Board of Occupational Therapy		37 MoReg 187		
20 CSR 2220-2.145	State Board of Pharmacy		37 MoReg 190		
20 CSR 2220-6.060	State Board of Pharmacy		37 MoReg 244		
20 CSR 2220-6.070	State Board of Pharmacy		37 MoReg 245		
20 CSR 2220-6.080	State Board of Pharmacy		37 MoReg 251		
20 CSR 2231-2.010	Division of Professional Registration		37 MoReg 48		
20 CSR 2233-1.010	State Committee of Marital and Family Therapists		36 MoReg 2926	37 MoReg 468	
20 CSR 2233-1.030	State Committee of Marital and Family Therapists		36 MoReg 2926	37 MoReg 469	
20 CSR 2233-1.040	State Committee of Marital and Family Therapists	36 MoReg 2900	36 MoReg 2927	37 MoReg 469	

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20 CSR 2233-1.050	State Committee of Marital and Family Therapists		36 MoReg 2930	37 MoReg 469	
20 CSR 2233-2.020	State Committee of Marital and Family Therapists		36 MoReg 2930	37 MoReg 538	
20 CSR 2233-2.021	State Committee of Marital and Family Therapists		36 MoReg 2932R 36 MoReg 2932	37 MoReg 538R 37 MoReg 538	
20 CSR 2233-2.030	State Committee of Marital and Family Therapists		36 MoReg 2933	37 MoReg 538	
20 CSR 2233-2.050	State Committee of Marital and Family Therapists		36 MoReg 2934	37 MoReg 538	
20 CSR 2233-3.010	State Committee of Marital and Family Therapists		36 MoReg 2935	37 MoReg 539	
20 CSR 2250-4.070	Missouri Real Estate Commission		36 MoReg 2709	37 MoReg 469	
20 CSR 2250-7.070	Missouri Real Estate Commission		36 MoReg 2710	37 MoReg 469	
20 CSR 2250-8.030	Missouri Real Estate Commission		36 MoReg 2710	37 MoReg 469	
20 CSR 2250-8.120	Missouri Real Estate Commission		36 MoReg 2711	37 MoReg 470	
20 CSR 2270-1.021	Missouri Veterinary Medical Board		37 MoReg 190		
20 CSR 2270-2.031	Missouri Veterinary Medical Board		37 MoReg 191		
20 CSR 2270-2.041	Missouri Veterinary Medical Board		37 MoReg 195		
20 CSR 2270-3.020	Missouri Veterinary Medical Board		37 MoReg 199		
	MISSOURI FAMILY TRUST				
21 CSR 10-1.010	Director and Board of Trustees	36 MoReg 2900R	36 MoReg 2936R	37 MoReg 470R	
21 CSR 10-1.020	Director and Board of Trustees	36 MoReg 2901R	36 MoReg 2936R	37 MoReg 470R	
21 CSR 10-1.030	Director and Board of Trustees	36 MoReg 2902R	36 MoReg 2936R	37 MoReg 470R	
21 CSR 10-2.010	Director and Board of Trustees	36 MoReg 2902R	36 MoReg 2936R	37 MoReg 470R	
21 CSR 10-3.010	Director and Board of Trustees	36 MoReg 2903R	36 MoReg 2937R	37 MoReg 470R	
21 CSR 10-4.010	Director and Board of Trustees	36 MoReg 2904R	36 MoReg 2937R	37 MoReg 471R	
21 CSR 10-4.020	Director and Board of Trustees	36 MoReg 2905R	36 MoReg 2937R	37 MoReg 471R	
	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-1.010	Health Care Plan		36 MoReg 2711	This Issue	
22 CSR 10-1.020	Health Care Plan		36 MoReg 2712	This Issue	
22 CSR 10-2.010	Health Care Plan	36 MoReg 2455	36 MoReg 2712	This Issue	
22 CSR 10-2.020	Health Care Plan	36 MoReg 2463R 36 MoReg 2463	36 MoReg 2719R 36 MoReg 2720	This IssueR This Issue	
22 CSR 10-2.030	Health Care Plan	36 MoReg 2471	36 MoReg 2730	This Issue	
22 CSR 10-2.045	Health Care Plan	36 MoReg 2472	36 MoReg 2734	This Issue	
22 CSR 10-2.051	Health Care Plan	36 MoReg 2473	36 MoReg 2735	This Issue	
22 CSR 10-2.052	Health Care Plan	36 MoReg 2475	36 MoReg 2739	This Issue	
22 CSR 10-2.053	Health Care Plan	36 MoReg 2476	36 MoReg 2742	This Issue	
22 CSR 10-2.054	Health Care Plan		36 MoReg 2746	This Issue	
22 CSR 10-2.055	Health Care Plan	36 MoReg 2477R 36 MoReg 2478	36 MoReg 2749R 36 MoReg 2749	This IssueR This Issue	
22 CSR 10-2.060	Health Care Plan		36 MoReg 2756	This Issue	
22 CSR 10-2.070	Health Care Plan		36 MoReg 2760	This Issue	
22 CSR 10-2.075	Health Care Plan	36 MoReg 2482	36 MoReg 2761	This Issue	
22 CSR 10-2.090	Health Care Plan	36 MoReg 2486	36 MoReg 2764	This Issue	
22 CSR 10-2.091	Health Care Plan	36 MoReg 2488	36 MoReg 2769	37 MoReg 471	
22 CSR 10-2.092	Health Care Plan		36 MoReg 2770R 36 MoReg 2770	This IssueR This Issue	
22 CSR 10-2.093	Health Care Plan		36 MoReg 2772R 36 MoReg 2772	This IssueR This Issue	
22 CSR 10-2.094	Health Care Plan	36 MoReg 2489	36 MoReg 2774	37 MoReg 471	
22 CSR 10-2.095	Health Care Plan	36 MoReg 2490	36 MoReg 2776	This Issue	
22 CSR 10-2.100	Health Care Plan	36 MoReg 2491	36 MoReg 2778	This Issue	
22 CSR 10-3.010	Health Care Plan	36 MoReg 2491	36 MoReg 2778	This Issue	
22 CSR 10-3.020	Health Care Plan	36 MoReg 2498R 36 MoReg 2499	36 MoReg 2785R 36 MoReg 2785	This IssueR This Issue	
22 CSR 10-3.030	Health Care Plan		36 MoReg 2794	This Issue	
22 CSR 10-3.045	Health Care Plan	36 MoReg 2505	36 MoReg 2798	This Issue	
22 CSR 10-3.053	Health Care Plan	36 MoReg 2506	36 MoReg 2799	This Issue	
22 CSR 10-3.054	Health Care Plan	36 MoReg 2507	36 MoReg 2803	This Issue	
22 CSR 10-3.055	Health Care Plan		36 MoReg 2806	This Issue	
22 CSR 10-3.056	Health Care Plan		36 MoReg 2809	This Issue	
22 CSR 10-3.057	Health Care Plan	36 MoReg 2508R 36 MoReg 2509	36 MoReg 2812R 36 MoReg 2812	This IssueR This Issue	
22 CSR 10-3.060	Health Care Plan		36 MoReg 2819	This Issue	
22 CSR 10-3.070	Health Care Plan		36 MoReg 2823	This Issue	
22 CSR 10-3.075	Health Care Plan	36 MoReg 2513	36 MoReg 2824	This Issue	
22 CSR 10-3.090	Health Care Plan	36 MoReg 2516	36 MoReg 2827	This Issue	
22 CSR 10-3.092	Health Care Plan		36 MoReg 2832R 36 MoReg 2832	This IssueR This Issue	
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22 CSR 10-3.100	Health Care Plan	36 MoReg 2519	36 MoReg 2837	This Issue	

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9 CSR 10-5.240	Health Home	37 MoReg 147	Jan. 1, 2012	June 28, 2012
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10 CSR 20-6.010	Construction and Operating Permits	36 MoReg 1892	Oct. 31, 2011	April 27, 2012
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11 CSR 30-12.010	Payment for Sexual Assault Forensic Examinations	37 MoReg 93	Dec. 17, 2011	June 13, 2012
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12 CSR 10-41.010	Annual Adjusted Rate of Interest	36 MoReg 2455	Jan. 1, 2012	June 28, 2012
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15 CSR 50-4.030	Missouri MOST 529 Matching Grant Program	May 15, 2012 Issue	April 15, 2012	Jan. 23, 2013
Department of Insurance, Financial Institutions and Professional Registration				
Insurer Conduct				
20 CSR 100-5.020	Grievance Review Procedures	36 MoReg 2897	Jan. 1, 2012	June 28, 2012
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20 CSR 200-18.030	Licensure of Motor Vehicle Extended Service Contract Producers	37 MoReg 150	Jan. 9, 2012	July 6, 2012
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20 CSR 700-1.160	Licensing and Authorization of Portable Electronics Insurance Producers and Related Entities	37 MoReg 150	Jan. 9, 2012	July 6, 2012
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20 CSR 2115-1.040	Fees	36 MoReg 2899	Dec. 20, 2011	June 16, 2012
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20 CSR 2233-1.040	Fees	36 MoReg 2900	Nov. 25, 2011	May 22, 2012
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21 CSR 10-1.020	Definitions	36 MoReg 2901	Nov. 25, 2011	May 22, 2012
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21 CSR 10-2.010	Terms and Conditions of the Missouri Family Trust	36 MoReg 2902	Nov. 25, 2011	May 22, 2012
21 CSR 10-3.010	Charitable Trust Regulations	36 MoReg 2903	Nov. 25, 2011	May 22, 2012
21 CSR 10-4.010	Administrative Fees for Missouri Family Trust Accounts	36 MoReg 2904	Nov. 25, 2011	May 22, 2012
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22 CSR 10-2.010	Definitions	36 MoReg 2455	Jan. 1, 2012	June 28, 2012
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22 CSR 10-2.020	General Membership Provisions	36 MoReg 2463	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.030	Contributions	36 MoReg 2471	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.045	Plan Utilization Review Policy	36 MoReg 2472	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.051	PPO 300 Plan Benefit Provisions and Covered Charges	36 MoReg 2473	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.052	PPO 600 Plan Benefit Provisions and Covered Charges	36 MoReg 2475	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.053	High Deductible Health Plan Benefit Provisions and Covered Charges	36 MoReg 2476	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges (Rescission)	36 MoReg 2477	Jan. 1, 2012	June 28, 2012
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22 CSR 10-2.094	Tobacco-Free Incentive Provisions and Limitations	36 MoReg 2489	Nov. 25, 2011	May 22, 2012

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22 CSR 10-2.095	TRICARE Supplement Plan	36 MoReg 2490	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.100	Fully-Insured Medical Plan Provisions	36 MoReg 2491	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.010	Definitions	36 MoReg 2491	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.020	Subscriber Agreement and General Membership Provisions (Rescission)	36 MoReg 2498	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.020	General Membership Provisions	36 MoReg 2499	Jan. 1, 2012	June 28, 2012
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22 CSR 10-3.053	PPO 1000 Plan Benefit Provisions and Covered Charges	36 MoReg 2506	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.054	PPO 2000 Plan Benefit Provisions and Covered Charges	36 MoReg 2507	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges (Rescission)	36 MoReg 2508	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges	36 MoReg 2509	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.075	Review and Appeals Procedure	36 MoReg 2513	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.090	Pharmacy Benefit Summary	36 MoReg 2516	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.100	Fully-Insured Medical Plan Provisions	36 MoReg 2519	Jan. 1, 2012	June 28, 2012

Executive Orders	Subject Matter	Filed Date	Publication
	2012		
12-05	Extends Executive Orders 11-06, 12-03, 11-07, 11-11, 11-14, and 12-04 until June 1, 2012	March 13, 2012	This Issue
12-04	Activates the state militia in response to severe weather that began on February 28, 2012	Feb. 29, 2012	37 MoReg 503
12-03	Declares a state of emergency and directs that the Missouri State Emergency Operations Plan be activated due to the severe weather that began on February 28, 2012	Feb. 29, 2012	37 MoReg 501
12-02	Orders the transfer of all authority, powers, and duties of all remaining audit and compliance responsibilities relating to Medicaid Title XIX, SCHIP Title XXI, and Medicaid Waiver programs from the Dept. of Health and Senior Services and the Dept. of Mental Health to the Dept. of Social Services effective Aug. 28, 2012, unless disapproved within sixty days of its submission to the Second Regular Session of the 96th General Assembly	Jan. 23, 2012	37 MoReg 313
12-01	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	Jan. 23, 2012	37 MoReg 311
	2011		
11-25	Extends the declaration of emergency contained in Executive Order 11-06 (and extended by Executive Orders 11-09, 11-19, and 11-23) until March 15, 2012, unless extended in whole or part by subsequent order. Further Executive Orders 11-07, 11-11, and 11-14 are extended until March 15, 2012, unless extended in whole or part by subsequent order	Dec. 14, 2011	37 MoReg 95
11-24	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	Nov. 18, 2011	37 MoReg 5
11-23	Extends Executive Order 11-20 until October 15, 2011, and extends Executive Orders 11-06, 11-07, 11-08, 11-11, 11-14, and 11-18 until December 18, 2011	Sept. 13, 2011	36 MoReg 2157
11-22	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	July 26, 2011	36 MoReg 1979
11-21	Authorizes the Joplin Public School system to immediately begin to retrofit, equip, and furnish various buildings to house students during the 2011-2012 school year without requiring advertisements for bids	June 17, 2011	36 MoReg 1800
11-20	Extends certain terms of Executive Order 11-12 to help Missouri citizens impacted by the Joplin tornado of April 22, 2011	June 17, 2011	36 MoReg 1798
11-19	Extends certain terms of Executive Orders 11-06, 11-07, 11-08, 11-10, 11-11, 11-13, 11-14, 11-15, 11-16, and 11-18 until September 15, 2011	June 17, 2011	36 MoReg 1796
11-18	Activates the state militia in response to flooding events occurring and threatening along the Missouri River	June 8, 2011	36 MoReg 1739
11-17	Establishes the State of Missouri Resource, Recovery & Rebuilding Center in the City of Joplin in response to a tornado that struck there on May 22, 2011	June 7, 2011	36 MoReg 1737
11-16	Authorizes the Joplin Public Schools to immediately begin to retrofit and furnish warehouse and retail structures to house district programs displaced by the tornado and severe storms on May 22, 2011, without requiring advertisements for bids	June 3, 2011	36 MoReg 1735
11-15	Authorizes the Joplin Public School system to immediately rebuild, restore, and/or renovate Emerson Elementary, Kelsey Norman Elementary, Old South Middle School, and Washington Education Center without requiring advertisement for bids	June 1, 2011	36 MoReg 1594
11-14	Activates the state militia in response to a tornado that hit the City of Joplin on May 22, 2011	May 26, 2011	36 MoReg 1592
11-13	Authorizes the Joplin Public Schools system to immediately begin rebuilding and replacing the materials for three of its buildings that were destroyed in a tornado that struck on May 22, 2011, without requiring advertisement for bids	May 26, 2011	36 MoReg 1590
11-12	Orders the director of the Department of Insurance, Financial Institutions and Professional Registration to temporarily waive, suspend, and/or modify any statute or regulation under his purview in order to best serve the interests of those citizens affected by the tornado that hit the city of Joplin on May 22, 2011	May 26, 2011	36 MoReg 1587

Executive Orders	Subject Matter	Filed Date	Publication
11-11	Orders the director of revenue to issue duplicate or replacement license, nondriver license, certificate of motor vehicle ownership, number plate, or tabs lost or destroyed as a result of the tornado that hit the city of Joplin and to waive all state fees and charges for such duplicate or replacement	May 26, 2011	36 MoReg 1585
11-10	Orders the Missouri Department of Health and Senior Services and the State Board of Pharmacy to temporarily waive certain rules and regulations to allow medical practitioners and pharmacists responding to the tornado and severe storms in Joplin to best serve the interests of public health and safety	May 24, 2011	36 MoReg 1583
11-09	Extends Executive Orders 11-06, 11-07, and 11-08 through June 20, 2011	May 20, 2011	36 MoReg 1581
11-08	Activates the state militia in response to severe weather that began on April 22	April 25, 2011	36 MoReg 1449
11-07	Gives the director of the Department of Natural Resources the authority to temporarily suspend regulations in the aftermath of severe weather that began on April 22	April 25, 2011	36 MoReg 1447
11-06	Declares a state of emergency for the state of Missouri and activates the Missouri State Emergency Operations Plan due to severe weather that began on April 22	April 22, 2011	36 MoReg 1445
11-05	Orders the Missouri Department of Transportation to assist local jurisdictions in counties that: 1) received record snowfalls; and 2) continuing snow clearance exceeds their capabilities	Feb. 4, 2011	36 MoReg 883
11-04	Activates the state militia in response to severe weather that began on January 31, 2011	Jan. 31, 2011	36 MoReg 881
11-03	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated	Jan. 31, 2011	36 MoReg 879
11-02	Extends the declaration of emergency contained in Executive Order 10-27 and the terms of Executive Order 11-01 through February 28, 2011	Jan. 28, 2011	36 MoReg 877
11-01	Gives the Director of the Department of Natural Resources the authority to temporarily suspend regulations in the aftermath of severe winter weather that began on December 30	Jan. 4, 2011	36 MoReg 705

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