AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the ***Missouri Register****.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 85—Division of Business and Community Services
Chapter 9—Amateur Sporting Tax Credit Program

EMERGENCY RULE

4 CSR 85-9.035 Support Contract

PURPOSE: The purpose of this rule is to explain the requirements for a properly submitted support contract.

EMERGENCY STATEMENT: Because section 67.3000, RSMo, caused the Amateur Sporting Tax Credit Program to become effective as of August 28, 2013, this emergency rule is authorized by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the ***Missouri Register****. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the* ***Missouri Register****. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

(1) The following will be included as part of the support contract submission:

(A) The Support Contract Submission Form, included herein; and

(B) A final executed copy of the support contract.

(2) The department reserves the right to make reasonable request for additional documentation in order to approve or deny a Support Contract Submission Form.

(3) A project proposal must meet the following statutory criteria in order for the project to be approved for tax credits:

(A) There must be cap space available. If your project was given a reservation of tax credits at the project proposal stage, you will already have cap space allocated to your sporting event and department will review your support contract for statutory compliance;

(B) You can submit a project proposal along with a support contract submission;

(C) If the program cap has been reached, and your support contract submission would have been otherwise approved, your sporting event will be placed on administrative hold until the earlier of—

1. A date upon which there is cap space available due to other denials in the fiscal year covered by the application, at which point cap space will be reserved for the applicant; or

2. Until a date ninety (90) days following the end of the sporting event, at which point the project will be denied;

(D) A project will be denied, even if it had been previously approved, when it becomes apparent that the sporting event will not be held as indicated in the support contract. Denied projects shall have their reserved cap space allotted to other sporting events;

(E) The applicant and site selection organizations must be valid and fit within the appropriate definitions provided under 4 CSR 85-9.011;

(F) No site for a sporting event may have been chosen prior to December 1, 2012, and no support contract will be approved after August 28, 2019; and

(G) No support contract will be certified unless the site selection organization has chosen to use a location in Missouri during a competitive bidding process in which at least one (1) competitive bid came from out of state.

MISSOURI
Department of Economic Development

ASTCP
Support Contract
LOG NUMBER (OFFICIAL USE ONLY)

AMATEUR SPORTING TAX CREDIT PROGRAM
SUPPORT CONTRACT SUBMISSION FORM

NAME OF INDIVIDUAL OR ENTITY

IF APPLICANT IS A BUSINESS ENTITY:			IF APPLICANT IS AN INDIVIDUAL TAXPAYER:	
Partnership ☐ General ☐ Limited	Corporation ☐ Regular ☐ Subchapter S ☐ Trust ☐ LLC		☐ Property Owner ☐ Other (specify) _____	
NAME OF AUTHORIZED COMPANY OFFICIAL	TITLE		MAILING ADDRESS	
BUSINESS ADDRESS			CITY/TOWN	
CITY/TOWN	STATE	ZIP CODE	STATE	ZIP CODE
TELEPHONE	FAX		TELEPHONE	FAX
TAXPAYER IDENTIFICATION NUMBER (OR SOCIAL SECURITY NUMBER)			SOCIAL SECURITY NUMBER	
NAICS CODE (See Definitions in Guidelines)	BUSINESS SIZE (Number of Employees Including Company Owners)		SPOUSE SOCIAL SECURITY NUMBER (if applicable)	
EMAIL ADDRESS			EMAIL ADDRESS	

HAS THE ENTITY/INDIVIDUAL (1a) EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF **ANY STATE** AND, OR FEDERAL LAW?
☐ YES ☐ NO

IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.

☐ Applicant ☐ Owner ☐ Other (Consultant, etc.)

NAME		
ADDRESS		
CITY/TOWN	STATE	ZIP CODE
TELEPHONE	EMAIL ADDRESS	FAX

HAS THE 'CONTACT' EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF **ANY STATE** AND, OR FEDERAL LAW?
☐ YES ☐ NO

IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.

TYPE OF EVENT		
EVENT ADDRESS		
CITY/TOWN	STATE	ZIP CODE
COUNTY		
EVENT DATE		

PLEASE SUBMIT THE FOLLOWING ADDITIONAL DOCUMENTS:

☐ A copy of the Support Contract for the Sporting Event

☐ Explanation of any changes or updates to the Project Proposal

APPLICATION INSTRUCTIONS:
Support Contract Submission

1. **APPLICANT INFORMATION:**
Name: Provide the name of the individual or entity that is filing the application and will receive the tax credits. The tax credit certificate will be issued to the individual or entity entered as the applicant.

Type of Entity:
- If the applicant is a business entity, complete the appropriate information on the left. Check the appropriate box indicating the type of entity. Supply the name of an authorized company official and the address. Enter the entity's Taxpayer Identification Number. Supply the appropriate NAICS code (see Definitions in Guidelines). Enter the authorized company official's email address, if available. List the property owner.
- If the applicant is an individual, complete the appropriate information on the right. Check the appropriate box indicating if the individual is the property owner. Enter the individual's contact information. Supply the individual's Social Security Number and spouse's Social Security Number, if applicable. Enter the applicant's email address, if available. If the individual requesting tax credits is not the property owner, please list the owner.
- Special Note: For entities with flow-through tax treatment (e.g., partnerships, S-corporations, etc.), on a separate sheet include the name, address, and social security number or taxpayer ID number for all persons or entities with an ownership interest. Provide the percentage ownership interest for each taxpayer as of the time of the application. If the tax credits are to be certified other than pro rata according to the proportion of ownership interest, attach an executed agreement among the partners, members, or owners documenting the alternate distribution method.

2. **PROJECT CONTACT:**
Applicant/Owner/Other: Check the appropriate box and specify the name and contact information of the contact person. The Project Contact may be the applicant or a third-party contact. All correspondence from DED will be sent to the Project Contact.

3. **SPORTING EVENT INFORMATION:**
Note: If more than one Sporting Event is being applied for, please include a separate spreadsheet listing each separate Sporting Event. The spreadsheet should list all information in this section for each Sporting Event.
Type of Event: Please list the sport that will be played at the Sporting Event.
Address: Enter the address of the project site, including city/town, state, zip code, and county.
Event Date: Please list the date that the sporting event will be held. If no exact date for the event has been given, please give the narrowest possible range of dates.

4. **ADDITIONAL DOCUMENTS REQUIRED:**
A copy of the Support Contract for the Sporting Event: Please submit the event award notification, Joinder Undertaking, Joinder Agreement, or contract executed by an Applicant and a Site Selection Organization.
Explanation of any changes or updates to the Project Proposal: Please submit an explanation of any changes or updates to your Project Proposal, such an update can come in the form of an amended Project Proposal.

AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the ***Missouri Register****.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 85—Division of Business and Community Services
Chapter 9—Amateur Sporting Tax Credit Program

EMERGENCY RULE

4 CSR 85-9.041 Event Notification

PURPOSE: The purpose of this rule is to explain the requirements for an event notification.

EMERGENCY STATEMENT: Because section 67.3000, RSMo, caused the Amateur Sporting Tax Credit Program to become effective as of August 28, 2013, this emergency rule is authorized by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the ***Missouri Register****. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the* ***Missouri Register****. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

(1) The following will be included as part of the event notification:
(A) The Event Notification Form, included herein; and
(B) The schedule of prices for the sporting event.

(2) The event notification must be submitted to the department no earlier than thirty (30) days, and no more than sixty (60) days prior to the sporting event.

MISSOURI
Department of Economic Development

ASTCP EVENT NOTIFICATION

LOG NUMBER

AMATEUR SPORTING TAX CREDIT PROGRAM EVENT NOTIFICATION

NAME OF INDIVIDUAL OR ENTITY

IF APPLICANT IS A BUSINESS ENTITY:			IF APPLICANT IS AN INDIVIDUAL TAXPAYER:	
Partnership ☐ General ☐ Limited	Corporation ☐ Regular ☐ Subchapter S ☐ Trust ☐ LLC		☐ Property Owner ☐ Other (specify) _____	
NAME OF AUTHORIZED COMPANY OFFICIAL	TITLE		MAILING ADDRESS	
BUSINESS ADDRESS			CITY/TOWN	
CITY/TOWN	STATE	ZIP CODE	STATE	ZIP CODE
TELEPHONE	FAX		TELEPHONE	FAX
TAXPAYER IDENTIFICATION NUMBER (OR SOCIAL SECURITY NUMBER)			SOCIAL SECURITY NUMBER	
NAICS CODE (See Definitions in Guidelines)	BUSINESS SIZE (Number of Employees including Company Owners)		SPOUSE SOCIAL SECURITY NUMBER (if applicable)	
EMAIL ADDRESS			EMAIL ADDRESS	

HAS THE ENTITY/INDIVIDUAL (1a) EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW?
☐ YES ☐ NO

IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.

☐ Applicant ☐ Owner ☐ Other (Consultant, etc.)

NAME		
ADDRESS		
CITY/TOWN	STATE	ZIP CODE
TELEPHONE	EMAIL ADDRESS	FAX

HAS THE 'CONTACT' EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW?
☐ YES ☐ NO

IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.

TYPE OF EVENT		
EVENT ADDRESS		
CITY/TOWN	STATE	ZIP CODE
COUNTY		
EVENT DATE		

EXPECTED ATTENDANCE	ESTIMATED LOCAL ATTENDEES
ESTIMATED OUT-OF-STATE ATTENDEES	ESTIMATED TICKETS SOLD AT FACE VALUE
ARE LOCAL SPORTS TEAMS LIKELY TO PARTICIPATE IN THE SPORTING EVENT?	IF SO, WHAT TEAMS?

APPLICATION INSTRUCTIONS:
Event Notification

1. APPLICANT INFORMATION:

Name: Provide the name of the individual or entity that is filing the application and will receive the tax credits. The tax credit certificate will be issued to the individual or entity entered as the applicant.

Type of Entity:

- If the applicant is a business entity, complete the appropriate information on the left. Check the appropriate box indicating the type of entity. Supply the name of an authorized company official and the address. Enter the entity's Taxpayer Identification Number. Supply the appropriate NAICS code (see Definitions in Guidelines). Enter the authorized company official's email address, if available. List the property owner.
- If the applicant is an individual, complete the appropriate information on the right. Check the appropriate box indicating if the individual is the property owner. Enter the individual's contact information. Supply the individual's Social Security Number and spouse's Social Security Number, if applicable. Enter the applicant's email address, if available. If the individual requesting tax credits is not the property owner, please list the owner.
- Special Note: For entities with flow-through tax treatment (e.g., partnerships, S-corporations, etc.), on a separate sheet include the name, address, and social security number or taxpayer ID number for all persons or entities with an ownership interest. Provide the percentage ownership interest for each taxpayer as of the time of the application. If the tax credits are to be certified other than pro rata according to the proportion of ownership interest, attach an executed agreement among the partners, members, or owners documenting the alternate distribution method.

2. PROJECT CONTACT:

Applicant/Owner/Other: Check the appropriate box and specify the name and contact information of the contact person. The Project Contact may be the applicant or a third-party contact. All correspondence from DED will be sent to the Project Contact.

3. SPORTING EVENT INFORMATION:

Note: If more than one Sporting Event is being applied for, please include a separate spreadsheet listing each separate Sporting Event. The spreadsheet should list all information in this section for each Sporting Event.

Type of Event: Please list the sport that will be played at the Sporting Event.

Address: Enter the address of the project site, including city/town, state, zip code, and county.

Event Date: Please list the specific date or dates when the sporting event(s) will be held. If an alternative date will be used for reasons such as inclement weather, please list such dates. The Event Notification must be submitted to the DED during the Event Notification Period as defined above. The Event Date Listed in the Event Notification must be consistent with the Event Date listed in the Project Proposal.

4. EXPECTED EVENT TICKET AND ATTENDANCE INFORMATION:

Expected Attendance: The total number of spectators (including spectators paying less than Face Value for their tickets) expected at the event.

Estimated Local Attendees: The total number of spectators expected to come from within a ninety miles radius of the Sporting Event.

Estimated Out-of-State Attendees: The total number of spectators expected to come from out of state.

Estimated Average Ticket Sales Price: The average Face Value of all tickets to be sold at the Sporting Event.

Estimated Tickets Sold at Face Value: The total number of tickets sold for Face Value, as defined in the definitions section of the Guidelines.

AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the ***Missouri Register****.*

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 85—Division of Business and Community Services
Chapter 9—Amateur Sporting Tax Credit Program

EMERGENCY RULE

4 CSR 85-9.051 Cost Certification

PURPOSE: The purpose of this rule is to explain the process for submitting and approval of a final application.

EMERGENCY STATEMENT: Because section 67.3000, RSMo, caused the Amateur Sporting Tax Credit Program to become effective as of August 28, 2013, this emergency rule is authorized by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the ***Missouri Register****. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the* ***Missouri Register****. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

(1) The following will be included as part of the final application:
(A) The Final Application Form, included herein;
(B) The eligible cost listing, or listings; and
(C) Documentation of qualified expenses.

(2) The department reserves the right to make reasonable requests for additional documentation.

(3) The Department of Economic Development (DED) will use the information submitted to determine the final amount of tax credits to be issued. Tax credits will be issued in an amount equal to the lesser of—
(A) The one hundred percent (100%) of eligible costs incurred by the applicant; or
(B) Five dollars ($5) in tax credits for each admissions ticket sold for the sporting event.

(4) The eligibility of each cost shall be determined based upon a review of the costs submitted by the applicant. For tax credits to be issued on an eligible cost, that eligible cost must—
(A) Be supported by a valid proof of payment;
(B) Be supported by a valid invoice or itemized in a support contract; and
(C) Be listed on an Eligible Cost Listing Form.

MISSOURI
Department of Economic Development

ASTCP
COST CERTIFICATION
LOG NUMBER (OFFICIAL USE ONLY)

AMATEUR SPORTING TAX CREDIT PROGRAM
COST CERTIFICATION FORM

NAME OF INDIVIDUAL OR ENTITY

IF APPLICANT IS A BUSINESS ENTITY:			IF APPLICANT IS AN INDIVIDUAL TAXPAYER:	
Partnership ☐ General ☐ Limited	Corporation ☐ Regular ☐ Subchapter S ☐ Trust ☐ LLC		☐ Property Owner ☐ Other (specify) _____	
NAME OF AUTHORIZED COMPANY OFFICIAL	TITLE		MAILING ADDRESS	
BUSINESS ADDRESS			CITY/TOWN	
CITY/TOWN	STATE	ZIP CODE	STATE	ZIP CODE
TELEPHONE	FAX		TELEPHONE	FAX
TAXPAYER IDENTIFICATION NUMBER (OR SOCIAL SECURITY NUMBER)			SOCIAL SECURITY NUMBER	
NAICS CODE (See Definitions in Guidelines)	BUSINESS SIZE (Number of Employees Including Company Owners)		SPOUSE SOCIAL SECURITY NUMBER (if applicable)	
EMAIL ADDRESS			EMAIL ADDRESS	

HAS THE ENTITY/INDIVIDUAL (1a) EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW?
☐ YES ☐ NO

IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.

☐ Applicant ☐ Owner ☐ Other (Consultant, etc.)

NAME		
ADDRESS		
CITY/TOWN	STATE	ZIP CODE
TELEPHONE	EMAIL ADDRESS	FAX

HAS THE 'CONTACT' EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW?
☐ YES ☐ NO

IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.

TYPE OF EVENT		
EVENT ADDRESS		
CITY/TOWN	STATE	ZIP CODE
COUNTY		
EVENT DATE		

ELIGIBLE COSTS		AMOUNT
ESTIMATED TICKETS SOLD AT FACE VALUE (SECTION 6 ABOVE)	NUMBER OF TICKETS MULTIPLED BY $5	AMOUNT
	MAXIMUM TAX CREDITS	AMOUNT

ARE THERE OTHER LOCAL, FEDERAL, STATE OF MISSOURI TAX CREDITS OR GRANTS BEING APPLIED TOWARD THIS PROJECT?

☐ YES ☐ NO

IF YES, WHICH FEDERAL OR STATE PROGRAM? (SPECIFY AMOUNT IN SPACE PROVIDED.)

☐ Missouri Housing Development Commission $_____
☐ Brownfield $_____
☐ Enterprise Zone $ _____
☐ New Business Facility $ _____
☐ Federal Historic Preservation $_____
☐ Neighborhood Assistance $ _____
☐ Neighborhood Preservation $ _____
☐ Youth Opportunity $ _____
☐ Local Community Development Block Grant $ _____
☐ Community Development Block Grant $_____
☐ Other (please specify program(s) and amount) _____

IS THE APPLICANT (BUSINESS ENTITY) ENROLLED AND PARTICIPATING IN THE E-VERIFY PROGRAM?

☐ YES ☐ NO

Missouri statutes (Section 285.525-285.555, RSMo) require any business entity receiving a state-administered tax credit to participate in a federal work authorization program, which enables employers to electronically verify employment eligibility with respect to employees working in connection with the activities that qualify the applicant for this program.

To access the E-Verify website, go to: https://e-verify.uscis.gov/enroll

PLEASE SUBMIT THE FOLLOWING ADDITIONAL DOCUMENTS:

☐ A copy of the Eligible Cost Listing(s)

☐ Backup documentation for the expenses claimed on the Cost Certification Form.

1. I certify that I am an authorized representative of the applicant and, as such, am authorized to make the statement of affirmation contained herein.

2. The information submitted by the applicant to DED in connection with this application is true and correct and such information is consistent with documents provided to lenders, other government programs, or investors. The applicant hereby authorizes DED to verify such information.

3. Neither the applicant, nor any individual with an ownership interest in the applicant:

   a. Has committed a felony, is currently under indictment or charged with a felony, or is currently on parole or probation;
   b. Is delinquent with respect to any non-protested federal, state or local taxes or fees;
   c. Has filed, or is preparing to file, for bankruptcy, unless otherwise disclosed to DED; or
   d. Has failed to fulfill any obligation under any other state or federal program, including a failure to pay as agreed any accrual upon which tax credits were issued.

4. I will inform DED, if at any time before project completion, there is any change to the certifications made in paragraphs 3(a) through 3(d) of this statement of affirmation.

5. The applicant, and any vendors the applicant will utilize to perform the work associated with the project, are registered and in good standing with the Missouri Secretary of State's Office.

6. The applicant agrees to comply with any and all agreements made pursuant to the project, upon which tax credits are issued.

7. I certify that the applicant does NOT knowingly employ any person who is an unauthorized alien and that the applicant has complied with federal law (8 U.S.C. § 1324a) requiring the examination of an appropriate document or documents to verify that each individual is not an unauthorized alien.

8. I certify that applicant is enrolled and will participate in a federal work authorization program as defined in Section 285.525(6), RSMo., with respect to employees working in connection with the activities that qualify applicant for this program. I certify that the applicant will maintain and, upon request, provide to DED documentation demonstrating applicant's participation in a federal work authorization program with respect to employees working in connection with the activities that qualify applicant for this program.

9. The applicant understands that, pursuant to section 285.530.5, RSMo, a general contractor or subcontractor of any tier shall not be liable under sections 285.525 to 285.550 when such general contractor or subcontractor contracts with its direct subcontractor who violates section 285.530.1, if the contract binding the contractor and subcontractor affirmatively states that the direct subcontractor is not knowingly in violation of section 285.530.1 and shall not henceforth be in such violation and the contractor or subcontractor receives a sworn affidavit under the penalty of perjury attesting to the fact that the direct subcontractor's employees are lawfully present in the United States.

10. I understand that if the applicant is found to have employed an unauthorized alien, applicant may be subject to penalties pursuant to Sections 135.815, 285.025, and 285.535, RSMo.

11. I certify that (check the applicable box):

☐ **I have included a copy of the executed E-Verify Program for Employment Verification Memorandum of Understanding between the company/organization and the Department of Homeland Security, United States Citizenship and Immigration Services (DHS-USCIS) and Social Security Administration.**

☐ **I am not a business entity as defined in Section 285.525 (1) RSMo. Section 285.525(1) defines business entity as "any person or group of persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage or livelihood. The term "business entity" shall include but not be limited to self-employed individuals, partnerships, corporations, contractors, and subcontractors. The term "business entity" shall include any business entity that possesses a business permit, license, or tax certificate, issued by the state, any business entity that is exempt by law from obtaining such a business permit, any business entity that is operating unlawfully without such a business permit. The term "business entity" shall not include a self-employed individual with no employees or entities utilizing the services of direct sellers as defined in subdivision (17) of subsection 12 of section 288.034, RSMo."**

12. By submitting this application, I acknowledge that the applicant shall comply with Amateur Sporting Events Tax Credit Program requirements. I further acknowledge that the applicant's failure to comply with the Program requirements shall result in the return to DED of any remaining unexpended tax credit proceeds and repayment to DED the monetary value of any expended tax credit proceeds.

13. I certify under penalties of perjury that the above statements, information contained in the application and attachments are complete, true, and correct to the best of my knowledge. I also realize that failure to disclose material information regarding the applicant, its owners, or any other pertinent facts may result in criminal prosecution.

<table>
<tr><td>APPLICANT SIGNATURE</td><td>PRINT NAME</td><td>TITLE</td><td>DATE</td></tr>
<tr><td rowspan="4">NOTARY PUBLIC EMBOSSER SEAL</td><td colspan="3">On this _____ day of _____, 20____, appeared _____ to me personally known to be the person who executed the above certification, and acknowledges and states on his/her oath to me that he/she executed the same for the purpose therein stated.</td></tr>
<tr><td colspan="2">STATE OF</td><td>COUNTY</td></tr>
<tr><td>NOTARY PUBLIC NAME</td><td>MY COMMISSION EXPIRES</td><td rowspan="2">USE RUBBER STAMP IN AREA BELOW</td></tr>
<tr><td colspan="2">NOTARY PUBLIC SIGNATURE</td></tr>
</table>

APPLICATION INSTRUCTIONS: COST CERTIFICATION

1. **APPLICANT INFORMATION:**
Name: Provide the name of the individual or entity that is filing the application and will receive the tax credits. The tax credit certificate will be issued to the individual or entity entered as the applicant.

Type of Entity:
- If the applicant is a business entity, complete the appropriate information on the left. Check the appropriate box indicating the type of entity. Supply the name of an authorized company official and the address. Enter the entity's Taxpayer Identification Number. Supply the appropriate NAICS code (see Definitions in Guidelines). Enter the authorized company official's email address, if available. List the property owner.
- If the applicant is an individual, complete the appropriate information on the right. Check the appropriate box indicating if the individual is the property owner. Enter the individual's contact information. Supply the individual's Social Security Number and spouse's Social Security Number, if applicable. Enter the applicant's email address, if available. If the individual requesting tax credits is not the property owner, please list the owner.
- Special Note: For entities with flow-through tax treatment (e.g., partnerships, S-corporations, etc.), on a separate sheet include the name, address, and social security number or taxpayer ID number for all persons or entities with an ownership interest. Provide the percentage ownership interest for each taxpayer as of the time of the application. If the tax credits are to be certified other than pro rata according to the proportion of ownership interest, attach an executed agreement among the partners, members, or owners documenting the alternate distribution method.

2. **PROJECT CONTACT:**
Applicant/Owner/Other: Check the appropriate box and specify the name and contact information of the contact person. The Project Contact may be the applicant or a third-party contact. All correspondence from DED will be sent to the Project Contact.

3. **SPORTING EVENT INFORMATION:**
Note: If more than one Sporting Event is being applied for, please include a separate spreadsheet listing each separate Sporting Event. The spreadsheet should list all information in this section for each Sporting Event.
Type of Event: Please list the sport that has been played at the Sporting Event.
Address: Enter the address of the project site, including city/town, state, zip code, and county.
Event Date: Please list the date that the Sporting Event was held.

4. **TOTAL NUMBER OF REQUESTED TAX CREDITS:**
Eligible Costs: List the actual dollar value for all Eligible Costs.
Tickets Sold at Face Value: List the total number of Sporting Event tickets sold at Face Value.
Number of Tickets Multiplied by $5: Multiply the number of Tickets Sold at Face Value by $5.
Maximum Tax Credits: Enter the lesser of Eligible Costs or the Number of Tickets Multiplied by $5.

5. **OTHER INCENTIVES USED:**
Are there other State of Missouri tax credits being applied toward this project? Select the appropriate box. If "Yes," please indicate which programs are applicable. If no other programs are being applied to the project, check "No."

6. **PARTICIPATING IN THE E-VERIFY PROGRAM?**
   Please indicate yes or no. Participation in the E-Verify Program is a prerequisite of receiving ASTCP tax credits.

7. **ADDITIONAL DOCUMENTS REQUIRED:**
   A Copy of the Eligible Cost Listing Form(s): The Eligible Cost Listing Form(s) should be created using the template provided in Appendixes A & B.
   Backup Documentation for the Eligible Cost Listing Form(s): All costs listed on the Eligible Cost Listing Form(s) must be supported by both an Invoice and Proof of Payment. All Pledged Obligations must also be supported by the Support Contract.

8. **ASTCP – APPLICANT CERTIFICATION:**
   Must be signed and notarized.

Appendix A:

Template for Eligible Cost Listing Form

Costs Necessary for Conducting a Sporting Event, and Costs relating to Preparations Necessary for the Conduct of a Sporting Event.

Description of Expense	Method of Payment (Include Check No.)	Date Paid	Payee	Payor	Total Amount of Expense

Appendix B:

Template for Eligible Cost Listing Form

Pledged Obligations

Description of Expense	Specific Part of Support Contract Requiring this Expense	Method of Payment (Include Check No.)	Date Paid	Payee	Payor	Total Amount of Expense

AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the ***Missouri Register****.*

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2013.

EXECUTIVE ORDER
14-02

WHEREAS, on February 27, 1950, President Harry S. Truman issued a Presidential Proclamation establishing Armed Forces Day in the United States as a "fitting and proper … tribute to the Armed Forces as the servants and protectors of our Nation"; and

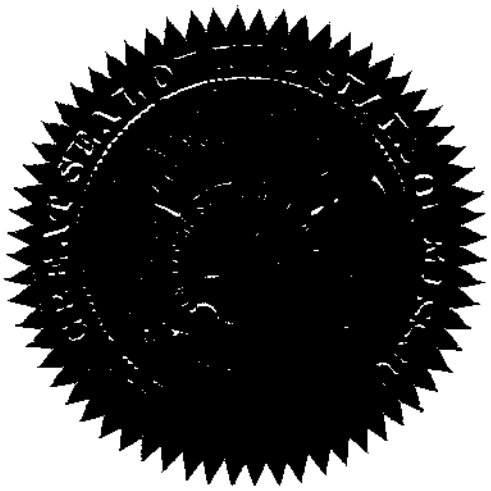
WHEREAS, throughout our nation's history, men and women serving in our military have paid the ultimate sacrifice defending our country and protecting individual liberty; and

WHEREAS, the Honor and Remember Flag is a proper tribute to the uncompromising devotion of those members of the armed services who gave their lives in defense of these ideals; and

WHEREAS, the State of Missouri wishes to recognize and honor the sacrifice of these brave men and women from Missouri and throughout the United States; and

WHEREAS, I previously directed the Honor and Remember Flag to be flown for a thirty-day period at the State Capitol and other state facilities at the seat of government as a mark of respect for the fallen members of the Armed Forces of the United States.

NOW THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, order the Honor and Remember Flag be flown at the State Capitol each Armed Forces Day, held on the third Saturday of every May, to commemorate and honor the fallen members of the Armed Forces of the United States. When displayed, the Honor and Remember Flag shall be no larger than the flags of the United States and the State of Missouri and shall be flown below such flags. If on separate poles, the Honor and Remember flag should be placed so that it is viewed to the right of the flags of the United States and the State of Missouri.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 20th day of March, 2014.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

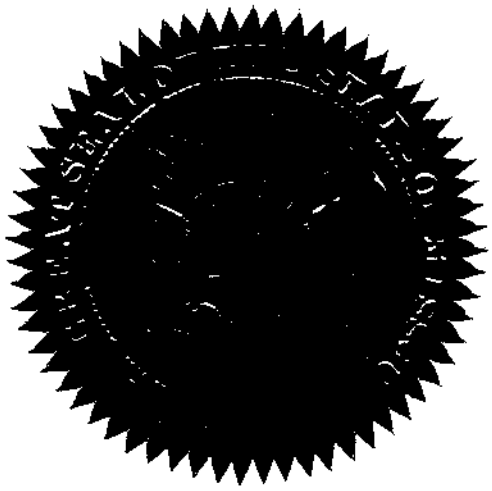
Jason Kander
Secretary of State

EXECUTIVE ORDER
14-03

WHEREAS, Section 105.454(5), RSMo, requires the Governor to designate those members of his staff who have supervisory authority over each department, division or agency of the state government.

NOW THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby designate the following members of my staff as having supervisory authority over the following departments, divisions or agencies:

Office of Administration	Emily Kalmer
Department of Agriculture	Peter Lyskowski
Department of Conservation	Peter Lyskowski
Department of Corrections	Edward R. Ardini, Jr.
Department of Economic Development	Chris Pieper
Department of Elementary and Secondary Education	Mike Nietzel
Department of Health and Senior Services	Peter Lyskowski
Department of Higher Education	Mike Nietzel
Department of Insurance, Financial Institutions and Professional Registration	Chris Pieper
Department of Labor and Industrial Relations	Jeff Harris
Department of Mental Health	Mike Nietzel
Department of Natural Resources	Peter Lyskowski
Department of Public Safety	Edward R. Ardini, Jr.
Department of Revenue	Peter Lyskowski
Department of Social Services	Mike Nietzel
Department of Transportation	Chris Pieper
Missouri Housing Development Commission	Brian May
Boards Assigned to the Governor	Chris Pieper
Unassigned Boards and Commissions	Chris Pieper



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 20th day of March, 2014.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Jason Kander
Secretary of State

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 or 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 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 100—Office of Quality Schools

ORDER OF RULEMAKING

By the authority vested in the Missouri State Board of Education under sections 161.092, 162.081, and 168.081, RSMo Supp. 2013, and section 167.031, RSMo 2000, the board rescinds a rule as follows:

5 CSR 20-100.170 Missouri School Improvement Program **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 2, 2013 (38 MoReg 1972). 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 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 5—Conduct of Gaming

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission (MGC) under section 313.805, RSMo Supp. 2013, the commission amends a rule as follows:

11 CSR 45-5.237 Shipping of Electronic Gaming Devices, Gaming Equipment or Supplies **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2019–2020). No changes have been made to 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: A public hearing was held on this proposed amendment on January 15, 2014. No one commented at the public hearing. No written comments were received.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission (MGC) under section 313.805, RSMo Supp. 2013, the commission adopts a rule as follows:

11 CSR 45-9.111 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2020–2021). Changes have been made to the *Minimum Internal Control Standards* (MICS) as incorporated by reference in Chapter K. Changes have been made to the text of the proposed rule, so it is reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed rule on January 15, 2014. Two (2) comments were received from Mike Winter, Executive Director of the Missouri Gaming Association.

COMMENT #1: The Missouri Gaming Association (MGA) would like to request MGC remove the last sentence from K §2.04 "If the transactions are not discovered until the compilation process, the transactions shall be logged by the individual performing the process."

The Multiple Transaction Log (MTL) is not a required document by the Financial Crimes Enforcement Network (FinCEN) and was created to assist casino employees in tracking a player's daily transaction. A player is added to the MTL when a single cash transaction of three thousand dollars ($3,000) or multiple cash transactions that accumulate to three thousand dollars ($3,000) have been observed. Additional increments of five hundred dollars ($500) are added after that threshold is reached. The MTL is a tool to assist the frontline casino employees to determine when a player has reached the ten thousand dollars and one cent ($10,000.01) Currency Transaction Report (CTR) threshold.

The MTL is utilized as a supporting document when filing CTRs. It is not intended to be the final document tracking all CTRs filed. It is primarily utilized by the frontline employees. It is only utilized during the compilation process as a verification tool. During the Title 31 Audit the MTL is utilized to assist in verifying the aggregation process. The Title 31 auditor will use the MTL and other reports to aggregate player's cash transactions. The auditor's job is to look for CTRs, not build an MTL. If this requirement is not removed, the Title 31 auditor would be required to spend a lot of time building the MTL when the information can be verified on separate reports. The

reports are all part of the Title 31 documents and retained for five (5) years.
RESPONSE AND EXPLANATION OF CHANGES: This sentence has been removed as requested.

COMMENT #2: The MGA would also like to address an industry concern relative to the filing of the CTR and Suspicious Activity Report (SAR) with the gaming agents. Gaming agents presently have access to this information through FinCEN. MGA believes that is still the avenue the gaming agents should use to begin their review of CTR and SAR reports.
RESPONSE: The gaming agents do not have access to this information through FinCEN unless they know the specific person for whom they need the records. Patterns of potential criminal activity can only be detected by monitoring the CTRs and SARs filed on an ongoing basis. No change has been made as a result of this comment.

11 CSR 45-9.111 Minimum Internal Control Standards (MICS)—Chapter K

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter K—Currency Transaction Reporting, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter K does not incorporate any subsequent amendments or additions as adopted by the commission on February 26, 2014.

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

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission (MGC) under section 313.805, RSMo Supp. 2013, the commission amends a rule as follows:

11 CSR 45-9.119 Minimum Internal Control Standards (MICS)—Chapter S **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2022). No changes have been made to the *Minimum Internal Control Standards* (MICS) as incorporated by reference in Chapter S. No changes have been made to 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: A public hearing was held on this proposed amendment on January 15, 2014. No one commented at the public hearing. No written comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 24—Community Programs

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, Family Support Division, under section 660.376, RSMo 2000, the Family Support Division adopts a rule as follows:

13 CSR 40-24.080 Formula for the Distribution of Community Service Block Grant Funds to Community Action Agencies **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2026–2031). 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 the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Family Support Division (FSD) received two (2) letters commenting on the proposed rule.

COMMENT #1: One (1) comment opposed the formula for distribution of community block grant funds contained in the proposed rule. The commenter argued that the proposed rule did not comply with the existing statutory language and would significantly underfund certain Missouri community action agencies (CAA). The authorized manner in which financial assistance to CAA must be distributed is found in section 660.374, RSMo. The CAA is to receive "a portion of available Community Services Block Grant Act funds based on that agency's poverty population relative to the state's total poverty population." The commenter urged that the proposed regulation did not follow this statutory authority. The commenter argued that the proposed rule should have based the Community Services Block Grant (CSBG) allocations on the CAA's poverty population and not give each CAA a base amount of two hundred thousand dollars ($200,000). This base funding is not supported by the statutory language, which lists proportion of poverty population as the only factor in determining distribution amounts. The commenter cited that state law requires state agencies to act within the bounds of the authority delegated to them by statute.

The commenter urged, in the alternative, that if the proposed rule was authorized to provide each CAA with a base amount, the amount chosen was capricious and arbitrary. Commenter argued that the base amount of two hundred thousand dollars ($200,000) is not based on any analysis about the true cost of providing a level of financial assistance for a CAA to carry out community action programs. The commenter urged that the base amount will lead to inequities in funding between CAAs.

The commenter further urged that the proposed rule would lead to results that are not in the spirit of the federal CSBG Act. FSD receives funds for the local CSBG program from the federal program and it has an obligation to comply with the federal statute. One of the goals of the federal program is the "maximum participation" of low-income residents. *42 U.S.C. section 9901(2)(D)*. As explained in *House Conference Report 105-788*, the CSBG Act is designed to assist with "the eradication of poverty, the revitalization of high poverty neighborhoods, and the empowerment of low income families and individuals to become fully self-sufficient."

The commenter argued that the proposed rule will not fulfill these goals. CSBG funds would not be targeted toward the areas with the greatest need or greatest number of low-income residents. As a result of the base funding, agencies with larger poverty populations will receive a smaller amount of funding than they should. For instance, for base year 2014, the commenter's CAA will receive approximately five hundred sixty-four thousand dollars ($564,000) less than it would under a rule based solely on poverty population. The proposed plan does not allow for maximum participation to the disadvantage of the areas that need it the most. The commenter provided data and tables supporting its argument regarding the differences in funding levels with and without the two hundred thousand dollar ($200,000) funding base.

The commenter also asserted that since the year 2000, FSD has improperly applied a never-defined "historical factor" when making distribution determinations to the agencies. This proposed rule fails to correct this error, but continues to use the "historical factor" as a

basis for establishing funding amounts to certain specific agencies. The commenter urged that the CSBG funding formulas should be solely based on the recently updated 2011 Poverty Rates with no provision given for any type of funding "base" for all agencies. The commenter urged that its position was also supported by the rule of "equitable" versus "fair."

To be "equitable and fair," the commenter urged, would be to allocate funding based on how many poverty individuals each agency is responsible to serve. In support of the commenter's argument, the commenter quoted several statements from Valerie Howard, Family Support Division Deputy Director, Income Maintenance. In summary, Ms. Howard's statements acknowledged there was disproportionate funding formula with the CSBG and that FSD was making efforts to correct this imbalance by creating a more equitable formula.

The commenter noted that its funding allocation amount will be $2,152,979 over the next five (5) years when, in fact the CAA will only be getting $1,638,562, based on an eighty percent (80%) recalculation of the formula inclusive of a per agency two hundred thousand dollar ($200,000) minimum funding base. The commenter asserted that its incorrect CSBG funding allocation amounts over the last thirteen (13) years, based on the revised poverty percentage census data, has resulted in funding shortages of over $10.5 million.

RESPONSE: Section 660.374, RSMo, authorizes the manner in which financial assistance to CAAs must be distributed. Under the statute, CAAs are to receive "a portion" of their mandatory allocation based on that agency's poverty population relative to the state's total poverty population. There is nothing in federal or state law that mandates that the entire, mandatory ninety percent (90%) of the CSBG be divided pro rata between the CAA based on the poverty population. The funding formula that FSD has adopted is fully consistent with federal and state law because it assures that each CAA receive "a portion" of their CAA funding based on the agency's poverty population relative to the state's total poverty population while assuring that the smaller CAAs serving rural areas will receive the minimum, base amount to continue operations. The formula in the proposed rule will require that most CSBG grant funding will still be allocated to the CAA pro rata based upon the poverty population. In FY 2014, seventy-six percent (76%) of the funds will be allocated on that basis.

The Family Support Division (FSD) consulted extensively with Missouri's CAAs during the last two (2) years in order to determine the base allocation. Based on that consultation, FSD determined that the base amount of two hundred thousand dollars ($200,000) is the minimum amount necessary to maintain a CAA's operations. None of the CAAs disputed that this base amount was the minimum necessary to maintain operations. This base amount is particularly necessary for those CAAs that are located in rural areas because the amount these agencies would receive if funded based one hundred percent (100%) on poverty is not enough to continue operations. FSD determined that it was critically important to keep funding levels for CAAs serving rural poverty areas at a base amount to assure that they will not have to close their doors and to continue services to rural poverty areas.

The "historical factor" noted by the commenter nearly doubled three CAAs' poverty rates to fund them twice as much as the remaining sixteen (16) agencies. Unfortunately, the current administrators of the CSBG program were unable to identify any information in its records that documented the reason for this decision. Thus, FSD worked with Missouri's CAAs to rectify the distribution based on this historical factor. The collaboration resulted in the new funding formula and ultimately this proposed rule.

Allocations of mandatory funds to CAAs shall be based on the most recent information on availability and amounts of CSBG funding to be awarded to Missouri by the U.S. Department of Health and Human Services, Office of Community Services as of the date that the Family Support Division issues the award. All distributions to CAAs are contingent on the availability of CSBG funds for that fiscal year. FSD may increase or decrease the funds awarded to a CAA during the grant term depending on the availability of CSBG funds awarded to the State of Missouri by the United States Department of Health and Human Services, Office of Community Support, for the administration of the CSBG program.

No changes have been made to the rule as a result of this comment.

COMMENT #2: One commenter expressed support for these proposed rules and the CSBG funding allocation contained in these proposed regulations. The commenter believes the funding allocation was fair and in accordance with the intent of the CSBG. The updated funding allocation will assist the commenter's agency to address the increase in people living below the poverty level as the median income in commenter's counties has decreased.

RESPONSE: This comment does not require further response as the comment agrees with the purpose and intent of the proposed rule. No changes have been made to the rule as a result of this comment.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 24—Community Programs

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, Family Support Division, under section 660.376, RSMo 2000, the Family Support Division adopts a rule as follows:

13 CSR 40-24.090 Supplemental Funding Formula for Community Action Agencies to Administer the CSBG Program **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2032–2034). 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 the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Family Support Division (FSD) received two (2) letters commenting on the proposed rule.

COMMENT #1: One (1) comment opposed how FSD will supplement Community Service Block Grant (CSBG) funds for those Community Action Agencies (CAAs) that will be receiving less than the proportional share in federal fiscal year 2013. The commenter argued that the proposed rule would continue to use a current year and future portion(s) of CSBG discretionary funds to overfund agencies that do not have the poverty populations that warrant funding beyond their equitable allocation for a future period of five (5) years.

The commenter argued that since FY 2000, the flawed funding formula used by FSD had a significantly negative funding impact on the commenter's CAA. The poverty percentage advanced by FSD for the commenter's CAA was calculated at eleven and seventy-eight hundredths percent (11.78%) while revised census data shows that the poverty percentage stands at sixteen and thirty-five hundredths percent (16.35%). At the same time, there were at least five (5) other CAAs that were allocated funding percentages twice over what they should have received. If the commenter's CAA were to calculate its correct CSBG funding allocation amounts over the last thirteen (13) years, based on the revised poverty percentage census data, it has had accumulative funding shortages of over $10.5 million.

The commenter requested that since its CAA has received less than its proportional share of CSBG funding for the low-income residents it serves, can some CSBG discretionary or legislature-appropriated supplemental funds be designated to it?

RESPONSE: Section 660.374, RSMo, authorizes the manner in

which financial assistance to CAA must be distributed. Under the statute, CAAs are to receive "a portion" of their mandatory allocation based on that agency's poverty population relative to the state's total poverty population. There is nothing in federal or state law that mandates that the entire, mandatory ninety percent (90%) of the CSBG be divided pro rata between the CAAs based on the poverty population. The funding formula that Missouri has adopted is fully consistent with federal and state law because it assures that each CAA receive "a portion" of their funding based on the agency's poverty population relative to the state's total poverty population while assuring that the smaller CAA serving rural areas will receive the minimum, base amount to continue operations. The formula in the proposed rule will require that most CSBG grant funding will still be allocated to the CAA pro rata based upon the poverty population. In FY 2014, seventy-six percent (76%) of the funds will be allocated on that basis.

The Family Support Division (FSD) consulted extensively with Missouri's CAAs during the last two (2) years in order to determine the base allocation. Based on that consultation, FSD determined that the base amount of two hundred thousand dollars ($200,000) is the minimum amount necessary to maintain a CAA's operations. None of the CAAs disputed that this base amount was the minimum necessary amount to maintain operations. This base amount is particularly necessary for those CAAs that are located in rural areas because the amount these agencies would receive if funded based one hundred percent (100%) on poverty is not enough to continue operations. FSD determined that it was critically important to keep funding levels for CAAs serving rural poverty areas at a base amount to assure that they will not have to close their doors and to continue services to rural poverty areas.

Allocations of mandatory funds to CAAs shall be based on the most recent information on availability and amounts of CSBG funding to be awarded to Missouri by the U.S. Department of Health and Human Services, Office of Community Services as of the date that the Family Support Division issues the award. Any and all distributions to CAAs are contingent on the availability of CSBG funds for that fiscal year. FSD may increase or decrease the funds awarded to a CAA during the grant term depending on the availability of CSBG funds awarded to the State of Missouri by the United States Department of Health and Human Services, Office of Community Support, for the administration of the CSBG program.

The request of the commenter for additional CSBG discretionary or legislature-appropriated supplemental funds be designated for the commenter's CAA is outside the scope of this proposed rule and further comment is not required. No changes have been made to the rule as a result of this comment.

COMMENT #2: One (1) commenter expressed support for these proposed rules and the CSBG funding allocation contained in these proposed regulations. The commenter believes the funding allocation was fair and in accordance with the intent of the CSBG. The updated funding allocation will assist the commenter's agency to address the increase in people living below the poverty level as the median income in commenter's counties has decreased.
RESPONSE: This comment does not require further response as the comment agrees with the purpose and intent of the proposed rule. No changes have been made to the rule as a result of this comment.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 24—Community Programs

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, Family Support Division, under section 660.376, RSMo 2000, the Family Support Division adopts a rule as follows:

13 CSR 40-24.100 Use of Community Service Block Grant Discretionary Funds **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2035–2038). 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 the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Family Support Division (FSD) received two (2) letters commenting on the proposed rule.

COMMENT #1: One (1) comment opposed how FSD will use Community Service Block Grant (CSBG) funds awarded to FSD by the U.S. Department of Health and Human Services for the administration of the Community Service Block Grant (CSBG) program. The commenter's opposition to this proposed rule focuses on FSD arbitrarily awarding unsubstantiated funding, discretionary or supplemental, to agencies that "receive Community Service Block Grant (CSBG) funds for less than the proportional share…" Commenter's Community Action Agency (CAA) has for numerous years received less than its proportional share of CSBG funding for the relative proportional poverty residents it serves. Commenter demands that some CSBG discretionary or legislature-appropriated supplemental funds be designated to its CAA for all the years it received less than the appropriate "proportional share." The commenter urged that the low-income residents of Kansas City equally deserve and are entitled to all the array of benefits in achieving self-sufficiency afforded by appropriate funding levels of the federally-funded CSBG program.
RESPONSE: Section 660.374, RSMo, authorizes the manner in which financial assistance to CAA must be distributed. Under the statute, CAA are to receive "a portion" of their mandatory allocation based on that agency's poverty population relative to the state's total poverty population. There is nothing in federal or state law that mandates that the entire, mandatory ninety percent (90%) of the CSBG be divided pro rata between the CAA based on the poverty population. The funding formula that Missouri has adopted is fully consistent with federal and state law because it assures that each CAA receive "a portion" of their CAA funding based on the agency's poverty population relative to the state's total poverty population while assuring that the smaller CAAs serving rural areas will receive the minimum, base amount to continue operations. The formula in the proposed rule will require that most CSBG grant funding will still be allocated to the CAA pro rata based upon the poverty population. In FY 2014, seventy-six percent (76%) of the funds will be allocated on that basis.

The Family Support Division (FSD) consulted extensively with Missouri's CAAs during the last two (2) years in order to determine the base allocation. Based on that consultation, FSD determined that the base amount of two hundred thousand dollars ($200,000) is the minimum amount necessary to maintain a CAA's operations. FSD determined that it was critically important to keep funding levels for CAAs serving rural poverty areas at a base amount to assure that they will not have to close their doors and to continue services to rural poverty areas.

The proposed rule appropriately sets forth criterion to allocate CSBG discretionary funds among different CAAs. The request of the commenter for additional CSBG discretionary or legislature-appropriated supplemental funds be designated for the commenter's CAA is outside the scope of this proposed rule and further comment is not required.

No changes have been made to the rule as a result of this comment.

COMMENT #2: One (1) commenter expressed support for these proposed rules and the CSBG funding allocation contained in these

proposed regulations. The commenter believes the funding allocation was fair and in accordance with the intent of the CSBG. The updated funding allocation will assist the commenter's agency to address the increase in people living below the poverty level as the median income in commenter's counties has decreased.
RESPONSE: This comment does not require further response as the comment agrees with the purpose and intent of the proposed rule. No changes have been made to the rule as a result of this comment.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program

ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under section 208.159, RSMo 2000, and sections 208.153 and 208.201, RSMo Supp. 2013, the division amends a rule as follows:

13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/MR Services **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 15, 2014 (39 MoReg 245–248). 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 January 2, 2014 (39 MoReg 73). 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 January 2, 2014 (39 MoReg 73–74). 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 Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 74–75). 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 10-2.020 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 75–81). 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 ten (10) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that under subsection (2)(B), that clarification is needed regarding what happens if a member is enrolled in another Medicare Prescription Drug Plan (Part D).
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, paragraph (2)(B)7., was added that an individual enrolled in another non-MCHCP Medicare Prescription Drug Plan (Part D) is not eligible for medical coverage under MCHCP.

COMMENT #2: MCHCP staff commented that, under paragraph (2)(B)6., the new language regarding the deadline requirements for submission of the Retiree Enrollment form be removed and to reinstate the language from the 2013 rule. This change is required to be in alignment with section 103.085, RSMo.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment MCHCP has removed the amended language from paragraph (2)(B)6.

COMMENT #3: MCHCP staff commented that, under subparagraph (2)(B)6.A., this subparagraph is not in alignment with section 103.085, RSMo and should be removed.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment MCHCP has removed subparagraph (2)(B)6.A.

COMMENT #4: MCHCP staff commented that, under paragraph (2)(C)4., clarification is needed of how Medicare eligible survivors are enrolled and the timeframe for their enrollment.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, subparagraph (2)(C)4.A. was added that Medicare eligible survivors will continue to be enrolled at the same level of coverage.

COMMENT #5: MCHCP staff commented that, under paragraph (3)(A)4., clarification is needed that married employees who elected to "roll up" coverage and do not complete enrollment during the open enrollment period will continue to be "rolled up."
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, subparagraph (3)(A)4.C was added, that the combined family deductible and out-of-pocket maximum for married state employees who elected to enroll in the same health plan to meet only one (1) family deductible and out-of-pocket maximum will continue to do so if they do not complete enrollment during the open enrollment period and are defaulted into a plan.

COMMENT #6: MCHCP staff commented that, under subparagraph (3)(B)5.A., clarification is needed that a retiree who is currently enrolled in the High Deductible Health Plan and becomes Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.
COMMENT #7: UMR commented that subparagraph (3)(B)5.A., does not differentiate between a retiree that is not Medicare eligible and one that is. It is noted, in other language in the plan, that the non-Medicare eligible retiree that will become Medicare eligible within the next year should elect the 300 or 600 plan during open enrollment.
RESPONSE AND EXPLANATION OF CHANGE: Based on Comment #6 and Comment #7, part (3)(B)5.A.(I), was added that retirees enrolled in the High Deductible Health Plan who become Medicare eligible during the next year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

COMMENT #8: MCHCP staff commented that under subparagraph (3)(C)3.A., that if a terminated vested survivor is currently enrolled in the High Deductible Health Plan and becomes Medicare eligible during the next year, they will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, MCHCP added part (3)(C)3.A.(I), that terminated vested subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next year, will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

COMMENT #9: MCHCP staff commented that, under subparagraph (3)(D)3.A., clarification is needed if a long-term disability subscriber is currently enrolled in the High Deductible Health Plan and becomes Medicare eligible during the next year, they will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, part (3)(D)3.A.(I), was added that long-term disability subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

COMMENT #10: MCHCP staff commented that, under subparagraph (3)(E)4.A., clarification is needed that if a survivor is currently enrolled in the High Deductible Health Plan and becomes Medicare eligible during the next year, they will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, part (3)(E)4.A.(I), was added that a survivor enrolled in the High Deductible Health Plan who become Medicare eligible during the next year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

22 CSR 10-2.020 General Membership Provisions

(2) Eligibility Requirements.
(B) Retiree Coverage.
1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment. The employee may elect coverage for him/herself and dependents, provided the employee and any dependents have been continuously covered for health care benefits—
A. Through MCHCP since the effective date of the last open enrollment period;
B. Through MCHCP since the initial date of eligibility; or
C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.
2. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.
3. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.
4. If the retiree's spouse is a state active employee or retiree and currently enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.
5. A retiree who returns to state employment and becomes eligible for benefits through MCHCP will be treated as a new employee.
6. If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP 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.
7. An individual enrolled in another non-MCHCP Medicare Prescription Drug Plan (Part D) is not eligible for medical coverage.
(C) Survivor Coverage.
1. At the time of the subscriber's death, 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 from MOSERS or PSRS and his/her dependents may elect or continue coverage if the survivor and his/her dependents had coverage—

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

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to subscriber's death. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. A survivor of a retiree or terminated vested subscriber may continue coverage if the survivor had MCHCP coverage as a dependent at the time of the subscriber's death.

3. If a survivor adds a new spouse to his/her coverage and the survivor subsequently dies, the new spouse is no longer eligible for coverage.

4. If a survivor or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days after the first day of the month following the death of the employee, s/he cannot enroll at a later date.

A. Medicare enrolled survivors will continue to be enrolled at the same level of coverage following the death of the subscriber.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

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

2. An active employee may elect coverage and/or change coverage levels during the annual open enrollment period.

3. An active employee may apply for coverage for himself/herself and/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 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; or

C. If an active employee 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; or

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

4. If an employee is currently enrolled in the PPO 300 or PPO 600 plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the employee is currently enrolled in, effective the first day of the next calendar year.

A. If an employee is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If an employee is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

C. Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

5. If an employee is currently enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must submit one (1) of the following:

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

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days with proof of prior medical coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may add a dependent to his/her current coverage if one (1) of the following occurs:

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

B. Employer-sponsored group coverage loss. A retiree 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. If coverage was not maintained while on disability, the employee and his/her dependents may enroll within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is currently enrolled in, effective the first day of the next calendar year.

A. If a retiree is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

(I) Retirees enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

B. If a retiree is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

C. If a retiree is currently enrolled in the Medicare Prescription Drug Only Plan and does not complete enrollment during the open enrollment period, the retiree and his/her Medicare eligible dependents will be enrolled in the Medicare Prescription Drug Only Plan at the same level of coverage.

6. If a retiree is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

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

B. Employer-sponsored group coverage loss. A terminated vested subscriber 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.

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

3. If a terminated vested subscriber is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the terminated vested subscriber is currently enrolled in, effective the first day of the next calendar year.

A. If a terminated vested subscriber is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

(I) Terminated vested subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

B. If a terminated vested subscriber is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

4. If a terminated vested subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

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

B. Employer-sponsored group coverage loss. A long-term disability subscriber 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.

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

3. If a long-term disability subscriber is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the long-term disability subscriber is currently enrolled in, effective the first day of the next calendar year.

A. If a long-term disability subscriber is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

(I) Long-term disability subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

B. If a long-term disability subscriber is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

4. If a long-term disability subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of

coverage in the same plan(s), effective the first day of the next calendar year.

5. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

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

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

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the 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.

2. A survivor may add a dependent to his/her current coverage if one (1) of the following occurs:

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

B. Employer-sponsored group coverage loss. A 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. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the survivor is currently enrolled in, effective the first day of the next calendar year.

A. If a survivor is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

(I) Survivors who are enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

B. If a survivor is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

5. If a survivor is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

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 January 2, 2014 (39 MoReg 81–83). 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 three (3) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, the July 1, 2012 date in the purpose statement should be corrected to July 1, 2002.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, the July 1, 2012 date in the purpose statement was changed to reflect the correct date for the MCHCP contribution methodology for members retiring prior to July 1, 2002.

COMMENT #2: MCHCP staff commented that, under section (3), that it should be clarified in greater detail exactly how a retiree's premium subsidy is calculated for members enrolled in the PPO 300, PPO 600, and the High Deductible Health Plan.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification for exactly how a retiree's premium subsidy is calculated for members enrolled in the PPO 300, PPO 600, and the High Deductible Health Plan was made under section (3).

COMMENT #3: MCHCP staff commented that, under section (4), that it should be clarified in greater detail exactly how a retiree's premium subsidy is calculated for members enrolled in the Medicare Prescription Drug Only Plan.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification for exactly how a retiree's premium subsidy is calculated for members enrolled in the Medicare Prescription Drug Only Plan was made under section (4).

22 CSR 10-2.030 Contributions

PURPOSE: This amendment revises the MCHCP contribution methodology for members retiring prior to July 1, 2002, the billing schedule and due dates for direct bill for Medicare primary Consolidated Omnibus Budget Reconciliation Act (COBRA), long-term disability, leave of absence, terminated vested and retiree and survivor members; and adds language regarding the methodology for the MCHCP contribution toward the retiree premium for members enrolled in the Medicare Prescription Drug Only Plan and the effect

on coverage for non-payment of premium for Medicare primary subscribers.

(3) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium for members enrolled in the PPO 300, PPO 600, and the High Deductible Health Plan is based on either of the following:

(A) 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 retiree only PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium. In addition, for Medicare retirees covering dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. For Non-Medicare Retirees, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount the MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. The above calculations can be written by formula as follows:

Medicare Retiree MCHCP contribution = (2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium) + Medicare Retiree MCHCP dependent contribution (if any);

Non-Medicare Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium with tobacco-free incentive and the partnership incentive + Non-Medicare Retiree MCHCP dependent contribution (if any);

Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium at the rate tier the retiree has selected – Retiree only PPO 600 Plan total premium)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected.

Non-Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium with tobacco-free incentive and partnership incentive at the rate tier the retiree has selected – Retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected.

(4) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium for members enrolled in the Medicare Prescription Drug Only Plan is based on either of the following:

(A) The subsidy is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by MOSERS or PSRS multiplied by two and one half percent (2.5%), and capped at sixty-five percent (65%). The computed percentage is multiplied by the Medicare Prescription Drug Only Plan premium at the rate tier the retiree selected. The resulting product is the MCHCP contribution, which shall be subtracted from the total Medicare Prescription Drug Only Plan premium. The difference is the amount of the retiree contribution toward the Medicare Prescription Drug Only Plan premium. The above calculation can be written by formula as follows: Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Medicare Prescription Drug Only Plan premium; or

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (4)(A) is compared to fifty-two percent (52%) of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (4)(A) or fifty-two percent (52%) of the Medicare Prescription Drug Only 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 10-2.045 Plan Utilization Review Policy **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 83–84). 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 10-2.051 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 84–86). 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, under section (4), that it should be clarified that married active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers must provide the other spouse's Social Security Number (SSN) at the time of enrollment in order to meet only one (1) family deductible and out-of-pocket maximum.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under section (4), that married active employees who are MCHCP subscribers must provide the other spouse's Social Security Number (SSN) at the time of enrollment to be able to meet one (1) family deductible and out-of-pocket maximum.

COMMENT #2: UMR commented that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims UMR can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.
RESPONSE: No changes have been made as a result of this comment.

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

(4) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security Number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

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 10-2.052 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 87–88). 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, under section (4), that it should be clarified that married active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers must provide the other spouse's Social Security Number (SSN) at the time of enrollment in order to meet only one (1) family deductible and out-of-pocket maximum.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under section (4), that married active employees who are MCHCP subscribers must provide the other spouse's Social Security Number (SSN) at the time of enrollment to be able to meet one (1) family deductible and out-of-pocket maximum.

COMMENT #2: UMR commented that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims UMR can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.
RESPONSE: No changes have been made as a result of this comment.

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

(4) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security Number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

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 10-2.053 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 89–91). 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 six (6) comments on the proposed amendment.

COMMENT #1: UMR commented that, under section (9), UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement,

for foreign claims we can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.
RESPONSE: No changes have been made as a result of this comment.

COMMENT #2: MCHCP staff commented that, under section (10), the reference to section (11) needs to be changed to section (13).
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, under section (10), the reference to section (11) was changed to section (13) due to renumbering.

COMMENT #3: MCHCP staff commented that, under section (12), clarification is needed that Medicare eligible dependents of non-Medicare retired, non-active subscribers are not eligible for the High Deductible Health Plan.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, subsection (12)(A) was added to reflect that Medicare eligible dependents of non-Medicare retired subscribers are not eligible for the High Deductible Health Plan.

COMMENT #4: MCHCP staff commented that, under section (14), clarification is needed regarding Health Savings Account (HSA) contributions made to members who have a balance in a Health Care Flexible Spending Account (HCFSA) on January 1.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under section (14), that employees who enroll in the High Deductible Health Plan during open enrollment and who have a balance in an HCFSA on January 1 of the new plan year, cannot receive an HSA contribution from MCHCP until after the HCFSA grace period ends.

COMMENT #5: MCHCP staff commented that, under subsection (14)(A), clarification is needed that employees must be an active employee on each date the MCHCP HSA contribution is made, including contributions made after the HCFSA grace period.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (14)(A), that subscribers must be an active employee on each date the MCHCP HSA contribution is made, including contributions made after the HCFSA grace period.

COMMENT #6: MCHCP staff commented that, under subsection (14)(B), clarification is needed for which months MCHCP will make an HSA contribution, including contributions made after the HCFSA grace period.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (14)(B), that MCHCP will make an HSA contribution in the months of January and July. HSA contributions for subscribers who are affected by the HCFSA grace period will be made in April and July.

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

(10) A subscriber does not qualify for the High Deductible Health Plan (HDHP) if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (13) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The member has veteran's benefits that have been used within the past three (3) months.

(12) If a subscriber is enrolled in the HDHP and his/her status changes to Medicare primary during the plan year, the subscriber must enroll in the PPO 300 Plan or PPO 600 Plan within thirty-one (31) days of notice from MCHCP or if no plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan. A new plan deductible and out-of-pocket maximum will apply.

(A) Medicare eligible dependents of non-Medicare retired subscribers are not eligible for the High Deductible Health Plan.

(14) Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the employee must be an active employee on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Employees who enroll in the High Deductible Health Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends.

(B) The MCHCP contributions will be deposited into the subscriber's HSA bi-annually on the Friday after the first Thursdays in January and July as follows:

Deposit	Subscriber Only	All other coverage levels
January	$150.00	$300.00
April (delayed contribution due to health care FSA balance)	$150.00	$300.00
July	$150.00	$300.00

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 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2014 (39 MoReg 92). 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 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 January 2, 2014 (39 MoReg 92). 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 10-2.055 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 2, 2014 (39 MoReg 92–104). 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 four (4) comments on the proposed rule.

COMMENT #1: Fresenius Medical Care commented under section (2) that they suggest that a method for determining a defined rate of reimbursement during the transitional care period be developed. They suggested the method be based on one (1) of the following: 1) the provider must agree to the payment rate before being obligated to transitional care; or 2) define the rate of payment for transitional care as provider's billed charges; or 3) define the rate of payment as the prior contract rate.
RESPONSE AND EXPLANATION OF CHANGE: Based on Fresenius Medical Care comment, language has been added to clarify the rate of payment during the transitional period shall be the same fee as paid prior to leaving the network.

COMMENT #2: MCHCP staff commented that, under paragraph (4)(E)11., clarification is needed regarding replacement batteries for cochlear implant devices.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, paragraph (4)(E)11. was revised to include coverage for replacement batteries for cochlear implant devices.

COMMENT #3: MCHCP staff commented that, under paragraph (4)(E)27., clarification is needed regarding the coverage of professional fees for automated laboratory services.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(E)27., that professional charges for automated lab services performed by an out-of-network provider are not covered.

COMMENT #4: MCHCP staff commented that, under paragraph (4)(E)28., clarification is needed that newborns covered by the PPO 300 or PPO 600 Plan will be subject to deductible and coinsurance if the newborn's mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(E)28., that newborns covered by the PPO 300 or PPO 600 Plan will be subject to deductible and coinsurance if mother is not covered under the plan and that newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance.

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

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the same fee as paid prior to leaving the network. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Inpatient hospitalization at the time of the network change;

(N) Mental health services; or

(O) Related follow-up services within three (3) months of an acute injury or surgery.

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

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

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, Ana-Kit, and Epi-Pen kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years. ABA is 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 direct observation, measurement, and functional analysis of the relationship between environment and behavior;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

8. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period); and

E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;

10. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

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

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

13. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

14. 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 a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

15. 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;

16. Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

17. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with mental retardation, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

18. Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). 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;

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

20. 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);

21. 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);

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

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

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by a provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

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

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

25. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

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

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

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

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

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

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

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

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

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

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

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services 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; and

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

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

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

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

(c) A state-licensed psychologist;

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

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition or alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastamosis status;

(XXI) Acquired absence of stomach; and

(XXII) Ideopathic progressive polyneuropathy;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

28. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after 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. Newborns covered by the PPO 300 or PPO 600 Plan will be subject to deductible and coinsurance if mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance;

29. 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. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be 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;

30. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

31. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

32. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

33. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

34. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with a goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an intergral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion).

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

35. 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 and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. 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. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

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

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

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

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

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

38. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

39. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.

40. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

41. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

42. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. Travel is limited to a ten thousand dollar ($10,000) maximum per transplant.

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

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

(III) Meals—not covered.

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

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

43. Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

44. Vision. One (1) routine exam and refractions is covered 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 January 2, 2014 (39 MoReg 105–106). 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: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT #1: UMR commented that since "clinical eligibility" is not defined in the plan, these words be replaced with "medically necessary."
RESPONSE: No changes have been made to this rule as a result of this comment.

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 January 2, 2014 (39 MoReg 106). 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 January 2, 2014 (39 MoReg 107–109). 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: UMR commented under part (4)(B)2.D.(II) that the full address of the External Review organization has changed to include "HHS Federal Request."
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, MCHCP has added "HHS Federal Request" to the External Review organization's address in part (4)(B)2.D.(II).

COMMENT #2: MCHCP staff commented that, under subsection (6)(K), clarification is needed that the once per lifetime of the account appeal that MCHCP may approve when a subscriber missed a deadline does not apply to statutory deadlines and voluntary cancelations.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (6)(K), that this guideline may not be used to approve an appeal of a voluntary cancelation or an appeal of a deadline that is statutorily mandated.

22 CSR 10-2.075 Review and Appeals Procedure

(4) Appeal Process for Medical and Non-Medicare Primary Pharmacy Determinations.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210

(b) Expedited appeals must be communicated by (913) 202-5000 or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the member believes the claim should be paid, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Pharmacy Appeals—MH3
Mail Route BL0390
6625 W. 78th St.
Bloomington, MN 55439
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(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:

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancelation or an appeal of a deadline that is statutorily mandated;

(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment; and

(M) MCHCP may approve appeals of a late submission of a Preventive Lab form if the subscriber can provide substantiating evidence that the preventive lab screening was received timely, that the subscriber reasonably relied on the health care provider to submit the Preventive Lab form to the wellness vendor, and the health care provider failed to submit the Preventive Lab form to the wellness vendor prior to the May 31 due date.

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 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 2, 2014 (39 MoReg 109–112). 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 amends a rule as follows:

22 CSR 10-2.090 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 113–115). 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 six (6) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under part (1)(A)1.I.(I), clarification is needed for the dosage range for preventive Vitamin D coverage.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under part (1)(A)1.I.(I), that the dosage range for preventive Vitamin D is at or below 1000 IU of vitamin D_2 or D_3 per dose.

COMMENT #2: MCHCP staff commented that under subparagraph (1)(A)3.D., the family out-of-pocket maximum of twelve thousand dollars ($12,000) for prescription drugs is incorrect. The correct family out-of-pocket maximum is twelve thousand five hundred dollars ($12,500).
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, the out-of-pocket maximum was corrected to twelve thousand five hundred dollars ($12,500).

COMMENT #3: MCHCP staff commented that, under subpart (1)(B)1.D.(I)(a), clarification is needed for the percentage of coinsurance that applies to generic drugs filled through the home delivery program. The reference to birth control and tobacco cessation products should be removed from this paragraph because they are addressed in section (9) of this rule.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subpart (1)(B)1.D.(I)(a), that the coinsurance after deductible for a generic drug on the formulary is ten percent (10%). The reference to birth control and tobacco cessation products was removed.

COMMENT #4: MCHCP staff commented that, under subpart (1)(B)1.D.(I)(b), clarification is needed for the percentage of coinsurance that applies to brand drugs filled through the home delivery program. The reference to birth control and tobacco cessation products should be removed from this subpart because they are addressed in section (9) of this rule.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subpart (1)(B)1.D.(I)(b), that the coinsurance after deductible for a brand drug on the formulary is twenty percent (20%). The reference to birth control and tobacco cessation products was removed.

COMMENT #5: MCHCP staff commented that, under subpart (1)(B)1.D.(II)(b), clarification is needed for the percentage of coinsurance that applies to specialty brand drugs filled through the home delivery program.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subpart (1)(B)1.D.(II)(b), that the coinsurance after deductible for a specialty brand drug on the formulary is twenty percent (20%).

COMMENT #6: MCHCP staff commented that, under part (1)(B)1.E.(I), clarification is needed for the dosage range for preventive Vitamin D coverage.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under part (1)(B)1.E.(I), that the dosage range for preventive Vitamin D is at or below 1000 IU of vitamin D_2 or D_3 per dose.

22 CSR 10-2.090 Pharmacy Benefit Summary

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician to non-Medicare primary members.

(A) PPO 300 and PPO 600.

1. Network:

A. Generic copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic copayments: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Brand copayments: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary

(c) Non-formulary copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) A member must choose how maintenance prescriptions will be filled by notifying the pharmacy benefit manager (PBM) of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

I. If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to thirty-one- (31-) day supply. The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic copayment: Eight dollars ($8) for a generic drug on the formulary list.

(b) Brand copayment: Thirty-five dollars ($35) for a brand drug on the formulary.

(c) Non-formulary copayment: One hundred dollars ($100) for a drug not on the formulary;

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix;

G. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

H. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug; and

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable copayment.

A. Generic copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply for a drug not on the formulary.

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

A. Network and non-network out-of-pocket maximums are not separate;

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

C. Individual—six thousand two hundred fifty dollars ($6,250);

D. Family—twelve thousand five hundred dollars ($12,500).

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. Network:

A. Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

C. Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

I. If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs covered only through network home delivery for up to thirty-one (31) days.

(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the pharmacy benefit manager, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

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 10-2.110 General Foster Parent Membership Provisions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 115–116). 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 adopts a rule as follows:

22 CSR 10-2.140 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 2, 2014 (39 MoReg 116–118). 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 three (3) comments on the proposed rule.

COMMENT #1: MCHCP staff commented that throughout the rule, including the title and purpose statement, change "wellness" center to "health" center.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, references to the wellness center were changed to health center in the title, purpose statement, sections (1), (2), (3), and (4).

COMMENT #2: MCHCP staff commented that, under section (2), clarification is needed for the list of available services provided at the health center.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under section (2) that the health center provides only maintenance doses of allergy injections. Biometric screening, Emergency First Response for worksite injuries and treatment and monitoring of diabetes and hypertension were removed.

COMMENT #3: MCHCP staff commented that, under section (4), clarification is needed that an office visit includes laboratory services performed by the health center.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under section (4) that an office visit at the health center includes laboratory services performed by the health center.

22 CSR 10-2.140 Health Center Provisions, Charges, and Services

PURPOSE: This rule establishes the policy of the board of trustees in regard to provisions, charges, and services available to members of the Missouri Consolidated Health Care Plan (MCHCP) through the MCHCP health center.

(1) Eligibility. Active employees enrolled in an MCHCP medical plan shall be eligible for and able to access the services available at the health center as described in this rule.

(2) Available Services. The health center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:
(A) Sore throats/ears/headache;
(B) Strains/sprains/musculoskeletal problems;
(C) Non-specific abdominal pain;
(D) Non-specific chest pain;
(E) Cough;
(F) Sinus conditions;
(G) Allergies/allergy injections (maintenance doses only);
(H) Hormone injections;
(I) Immunizations including immunization for influenza;
(J) Rashes;
(K) Acute urinary complaints;
(L) Personal hygiene related problems;
(M) Acute injuries/acute routine office procedures;
(N) Minor surgical procedures, such as sutures for laceration treatment;
(O) Ordinary and routine care of the nature of a visit to the doctor's office; and
(P) Clinical Laboratory Improvement Amendments (CLIA)-waived lab services.

(3) Limitations and Exclusions.
(A) The following employees are not eligible for the health center:
1. Active employees who are not enrolled in an MCHCP medical plan;
2. Dependents of active employees; and
3. Retirees and their dependents.
(B) Services that are beyond the scope of practice of the health center including, but not limited to, the following:
1. Emergency services;
2. Urgent care services;
3. Radiology services;
4. Specialist services;
5. Pharmacy services;
6. Occupational, speech, and physical therapy services; and
7. Chiropractic services.

(4) Charges for the following services apply:
(A) Office visit—
1. For active employees enrolled in the MCHCP PPO 300 or PPO 600 Plan, fifteen dollars ($15) payable at the time of service;
2. For active employees enrolled in the High Deductible Health Plan, forty-five dollars ($45) payable at the time of service; and
3. The office visit includes the evaluation and management of the patient and any associated laboratory services performed by the health center.
(B) Preventive care—
1. For active employees enrolled in the MCHCP PPO 300 Plan, PPO 600 Plan, or High Deductible Health Plan, preventive care is covered at one hundred percent (100%); and
2. Preventive care shall have the same meaning as in 22 CSR 10-2.055.
(C) Health center services are outside the MCHCP PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan benefits and payments for center services do not apply toward any associated deductible or out-of-pocket maximum.

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 Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 119). 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 10-3.020 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 119–120). 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 amended language under paragraph (2)(B)4., regarding the deadline requirement for submission of the Retiree Enrollment Form should be removed and the language from the 2013 rule be reinstated to align with section 103.085, RSMo.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment MCHCP has removed the amended language from paragraph (2)(B)4.

COMMENT #2: MCHCP staff commented that the amended language under subparagraph (2)(B)4.A., regarding the deadline requirement for submission of the Retiree Enrollment Form should be removed and the language from the 2013 rule be reinstated to align with section 103.085, RSMo.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment MCHCP has removed subparagraph (2)(B)4.A.

22 CSR 10-3.020 General Membership Provisions

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is fully vested in the retirement plan upon termination and the public entity remains with MCHCP. The public entity must make the benefits available to all retirees, past and future, who meet the vesting requirements. The employee may elect coverage for him/herself and dependents, provided the employee and any dependents have been continuously covered for health care benefits—

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

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. If the retiree's spouse is an active public entity employee or retiree and currently enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

3. A retiree who returns to employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

4. If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP 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.

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 Plan Utilization Review Policy **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 120–121). 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 10-3.053 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 121–124). 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: UMR commented that, under the Public Entity rules that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims we can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.
RESPONSE: No changes have been made as a result of this comment.

COMMENT #2: UMR commented that there is a reference to 22 CSR 10-2.055 and 22 CSR 10-2.045 in section (9) that should refer to 22 CSR 10-3.055 and 10-3.045 instead.
RESPONSE AND EXPLANATION OF CHANGE: MCHCP intended to reference 22 CSR 10-3.057 and 22 CSR 10-3.045 and has corrected the reference in section (9).

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

(9) Services received while out of the country may be covered if the service is included in 22 CSR 10-3.057 and will be subject to any prior authorization requirements provided for in 22 CSR 10-3.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

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 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2014 (39 MoReg 125). 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 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 January 2, 2014 (39 MoReg 125–126). 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, under section (8), the reference to section (8) needs to be changed to section (9).
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, under section (8), the reference to section (8) was changed to section (9).

COMMENT #2: UMR commented that, under the Public Entity rules that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims we can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.
RESPONSE: No changes have been made as a result of this comment.

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

(8) A subscriber does not qualify for the High Deductible Health Plan (HDHP) if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (9) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The member has veteran's benefits that have been used within the past three (3) months.

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 January 2, 2014 (39 MoReg 126–127). 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: UMR commented that, under the Public Entity rules that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims we can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.
RESPONSE: No changes have been made as a result of this comment.

COMMENT #2: UMR commented that there is a reference to 22 CSR 10-2.055 and 22 CSR 10-2.045 in section (8) that should refer to 22 CSR 10-3.055 and 10-3.045 instead.
RESPONSE AND EXPLANATION OF CHANGE: MCHCP intended to reference 22 CSR 10-3.057 and 22 CSR 10-3.045 and has corrected the reference in section (8).

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

(8) Services received while out of the country may be covered if the service is included in 22 CSR 10-3.057 and will be subject to any prior authorization requirements provided for in 22 CSR 10-3.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

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 January 2, 2014 (39 MoReg 128). 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 January 2, 2014 (39 MoReg 128–140). 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 four (4) comments on the proposed rule.

COMMENT #1: Fresenius Medical Care commented under section (2) that they suggest that a method for determining a defined rate of reimbursement during the transitional care period be developed. They suggested the method be based on one (1) of the following: 1) the provider must agree to the payment rate before being obligated to transitional care; or 2) define the rate of payment for transitional care as provider's billed charges; or 3) define the rate of payment as the prior contract rate.
RESPONSE AND EXPLANATION OF CHANGE: Based on Fresenius Medical Care comment, language has been added to clarify that the rate of payment during the transitional period shall be the same fee as paid prior to leaving the network.

COMMENT #2: MCHCP staff commented that, under paragraph (4)(E)11., clarification is needed regarding replacement batteries for cochlear implant devices.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, paragraph (4)(E)11. was revised to include coverage for replacement batteries for cochlear implant devices.

COMMENT #3: MCHCP staff commented that, under paragraph (4)(E)27., clarification is needed regarding the coverage of professional fees for automated laboratory services.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(E)27., that professional charges for automated lab services performed by an out-of-network provider are not covered.

COMMENT #4: MCHCP staff commented that, under paragraph (4)(E)28., clarification is needed that newborns covered by the PPO 600 or PPO 1000 Plan will be subject to deductible and coinsurance if the newborn's mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(E)28., that newborns covered by the PPO 600 or PPO 1000 Plan will be subject to deductible and coinsurance if mother is not covered under the plan and that newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance.

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

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the same fee as paid prior to leaving the network. Benefits eligible for transition of care include:

(A) Upcoming surgery or prospective transplant;

(B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;

(C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;

(D) Home nursing care;

(E) Radiation therapy;

(F) Dialysis;

(G) Durable medical equipment;

(H) Cancer treatment;

(I) Clinical trials;

(J) Physical, speech, or occupational therapy;

(K) Hospice care;

(L) Bariatric surgery, and follow-up per criteria covered under the plan;

(M) Inpatient hospitalization at the time of the network change;

(N) Mental health services; or

(O) Related follow-up services within three (3) months of an acute injury or surgery.

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

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes services:

1. Prescribed by an appropriate provider for the therapeutic treatment of injury or sickness;

2. To the extent they do not exceed any limitation or exclusion; and

3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and

2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A provider visit to seek a second opinion.

(D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network

benefit. All other non-emergency services are covered at the non-network benefit.

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

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulan E- (IgE-) mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents).

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

(I) Foods;

(II) Hymenoptera venom (stinging insects);

(III) Inhalants; or

(IV) Specific drugs (penicillins and macromolecular agents).

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

(I) Hymenoptera venom (stinging insects); or

(II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or

(II) Skin testing is unreliable.

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

(I) Food or other substances; or

(II) Drugs when all of the following are met:

(a) History of allergy to a particular drug;

(b) There is no effective alternative drug; and

(c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;

(II) Food allergy;

(III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: Routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: The following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy; and

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, Ana-Kit, and Epi-Pen kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy.

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years. ABA is 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 direct observation, measurement, and functional analysis of the relationship between environment and behavior;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only:

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

8. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g.,Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination; or

J. Cystinuria;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation, or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period); and

E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;

10. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when:

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

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

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

13. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

14. 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 a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

15. 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;

16. Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease;

(III) Peripheral neuropathy; and

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

17. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with mental retardation, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

18. Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). 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;

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

20. 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);

21. 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).

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

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

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by a provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

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

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

25. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

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

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

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

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

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

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

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

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

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

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

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

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

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services 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; and

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

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

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

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

(c) A state-licensed psychologist;

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

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition or alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastamosis status;

(XXI) Acquired absence of stomach; and

(XXII) Ideopathic progressive polyneuropathy;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered.

28. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after 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. Newborns covered by the PPO 600 or PPO 1000 Plan will be subject to deductible and coinsurance if mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance;

29. 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. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be 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;

30. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings; and

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

31. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic,

or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

32. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

33. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

34. Orthotics.

A. Ankle–Foot Orthosis (AFO) and Knee–Ankle–Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions;

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with a goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom.

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an intergral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis; and

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion).

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

35. 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 and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. 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. Zoster vaccination (shingles)—The zoster vaccine is covered for members age of fifty (50) years and older;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

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

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

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

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

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

38. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

39. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.

40. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person.

41. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver-provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

42. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. Travel is limited to a ten thousand dollar ($10,000) maximum per transplant.

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

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

(III) Meals—not covered.

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

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

43. Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

44. Vision. One (1) routine exam and refraction is covered 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, and HDHP Limitations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 141–142). 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 January 2, 2014 (39 MoReg 142–145). 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: UMR commented that the full address of the External Review organization has changed to include "HHS Federal Request."
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, MCHCP has added "HHS Federal Request" to the External Review organization's address in part (4)(B)2.D.(II).

COMMENT #2: MCHCP staff commented that, under subsection (6)(J), clarification is needed that the once per lifetime of the account appeal that MCHCP may approve when a subscriber missed a deadline does not apply to statutory deadlines and voluntary cancellations.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (6)(J), that this guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated.

22 CSR 10-3.075 Review and Appeals Procedure

(4) Appeal Process for Medical and Pharmacy Determinations.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-32.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination

giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals
PO Box 400046
San Antonio, TX 78229

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210

(b) Expedited appeals must be communicated by calling (913) 202-5000 or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the member believes the claim should be paid, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts
Attn: Pharmacy Appeals—MH3
Mail Route BL0390
6625 W. 78th St.
Bloomington, MN 55439
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534
or by fax to (888) 866-6190
or to request a review online at
http://www.externalappeal.com/

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with

reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(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:

(J) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated; and

(K) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.

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 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 145–148). 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 three (3) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under part (1)(A)1.I.(I), clarification is needed for the dosage range for preventive Vitamin D coverage.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under part (1)(A)1.I.(I), that the dosage range for preventive Vitamin D is at or below 1000 IU of vitamin D_2 or D_3 per dose.

COMMENT #2: MCHCP staff commented that under subparagraph (1)(A)3.D., the family out-of-pocket maximum of twelve thousand dollars ($12,000) for prescription drugs is incorrect. The correct family out-of-pocket maximum is twelve thousand five hundred dollars ($12,500).
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, the out-of-pocket maximum was corrected to twelve thousand five hundred dollars ($12,500).

COMMENT #3: MCHCP staff commented that, under part (1)(B)1.E.(I), clarification is needed for the dosage range for preventive Vitamin D coverage.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under part (1)(B)1.E.(I), that the dosage range for preventive Vitamin D is at or below 1000 IU of vitamin D_2 or D_3 per dose.

22 CSR 10-3.090 Pharmacy Benefit Summary

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.

(A) PPO 600 and PPO 1000 Prescription Drug Coverage.

1. Network.

A. Generic copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty-four dollars ($24) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and one hundred and five dollars ($105) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Home delivery program—

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic copayments: Eight dollars ($8) for up to a thirty-one- (31-) day supply; sixteen dollars ($16) for up to a sixty- (60-) day supply; and twenty dollars ($20) for up to a ninety- (90-) day supply for a generic drug on the formulary.

(b) Brand copayments: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply; seventy dollars ($70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty-cents ($87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to a sixty- (60-) day supply; and two hundred fifty dollars ($250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d) A member must choose how maintenance prescription(s) will be filled by notifying the pharmacy benefit manager (PBM) of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(e) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(f) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply. The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic copayments: Eight dollars ($8) for a generic drug on the formulary list.

(b) Brand copayments: Thirty-five dollars ($35) for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred dollars ($100) for a drug not on the formulary; and

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

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix.

G. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

H. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug.

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable copayment.

A. Generic copayment: Eight dollars ($8) for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars ($35) for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars ($100) for up to a thirty-one- (31-) day supply for a drug not on the formulary.

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

A. Network and non-network out-of-pocket maximums are not separate.

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

C. Individual—six thousand two hundred fifty dollars ($6,250).

D. Family—twelve thousand five hundred dollars ($12,500).

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. Network.

A. Generic: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. Non-formulary: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(e) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(f) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs covered only through network home delivery for up to thirty-one- (31-) days.

(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary; and

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D_2 or D_3 per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the pharmacy benefit manager, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

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. 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. In addition, this list includes contractor(s) that have agreed to entry of an injunction permanently prohibiting them and any persons and entities related to them from engaging in, or having any involvement in, any business in Missouri.

Contractors Convicted of Violations of the Missouri Prevailing Wage Law

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Urban Metropolitan Development, LLC Case No. 12AO-CR01752 (Jasper County Cir. Ct.)		1101 Juniper St., Ste. 925 Atlanta, Georgia 30309	08/08/2013	08/08/2013 to 08/08/2014

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Contractors Agreeing to Permanent Prohibition from Engaging In, or Having Any Involvement In, Any Business in Missouri

Name of Contractor	Name of Officers	Address	Date of Injunction	Debarment Period
Urban Metropolitan Development, LLC		1101 Juniper St., Ste. 925 Atlanta, Georgia 30309	09/27/2013	Permanent
Troy Langley		1101 Juniper St., Ste. 925 Atlanta, Georgia 30309	09/27/2013	Permanent

Dated this 7th day of March 2014.

John E. Lindsey, Division Director